

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C7062

07053

1. PLACE OF DEATH

b. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN lb

49 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

13316 Andrew Drive

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE OF
DEATH

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED

WIDOWED

 DIVORCED

8. DATE OF BIRTH

Sep. 2, 1899

9. AGE (In years
last birthday)

66 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George West Acorn

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or date of service)

No

None

16. SOCIAL SECURITY NO.

YES

17. INFORMANT

Mrs. Dorothy D. Acorn

Address
5608 Western Ave.
Chevy Chase, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4201

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary occlusion

Immediate

Arteriosclerosis & congestive failure. 2 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

20a. ACCIDENT WAS UNDERLYING

 OR CONTRIBUTING CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a.m.

p.m.

20d. INJURY OCCURRED

While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from June 1959 to May 26, 1966, that (I) (we) last saw the deceased alive on May 16, 1966, and that death occurred at 11 P.M. from the causes and on the date stated above.

22a. SIGNATURE

A. J. Thibadeau

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE
SIGNED

5/28/66

22c. PHYSICIAN'S
NAME (Type)

A. J. Thibadeau

22d. ADDRESS

10111 Colesville, Rd., S. S., Md.

23a. BURIAL, CREMATION, DATE THEREOF

REMOVAL
(Specify)

Burial

June 1, 1966

Glenwood Cemetery

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)

(State)

Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE

John E. Pumphrey, Inc.

8434 Georgia Avenue

Silver Spring, Md.

JUN 3 1966

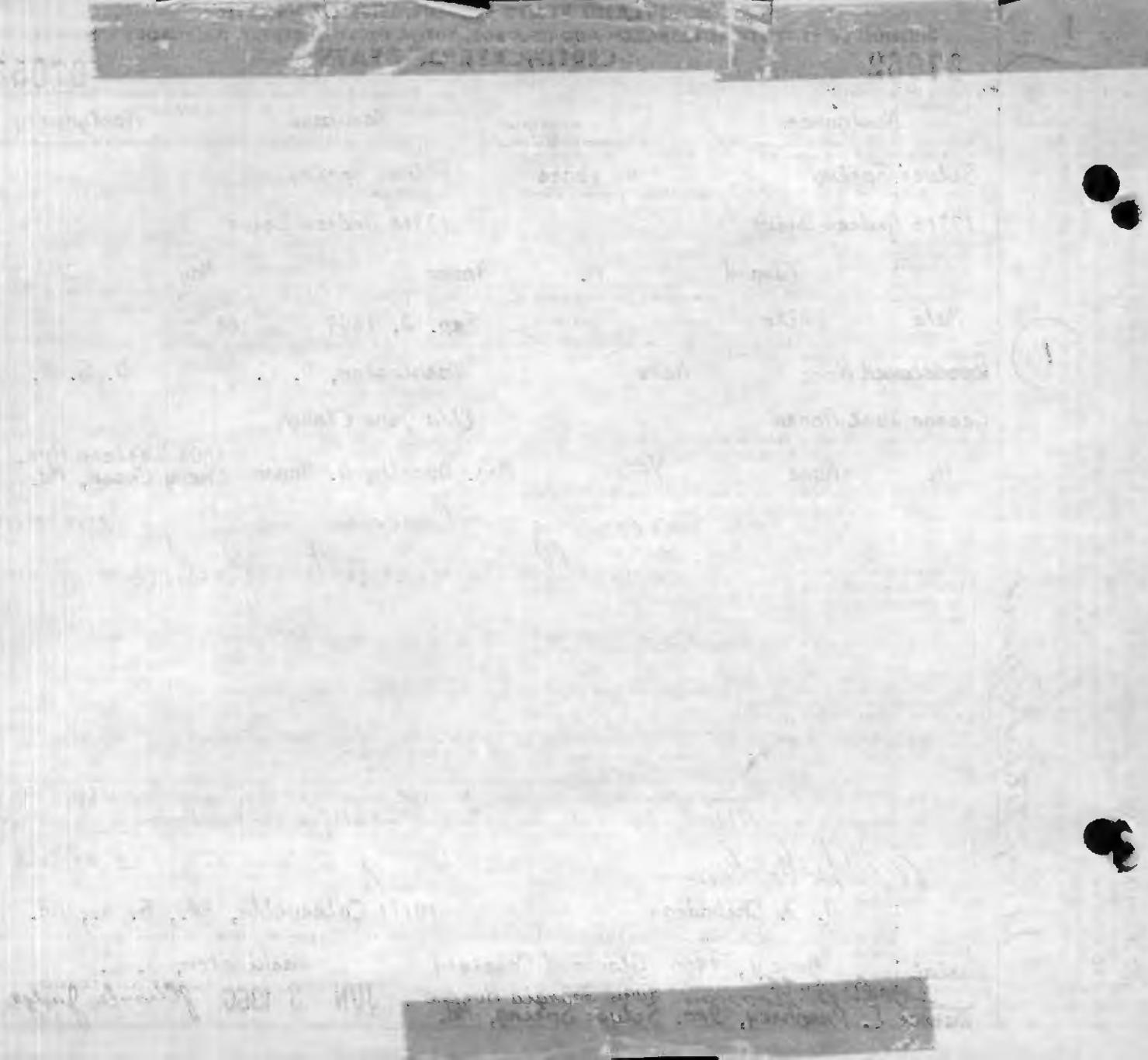
DATE

25b. REGISTRAR'S SIGNATURE

Charles Judge

Dr. Ray Thibadeau

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

07063

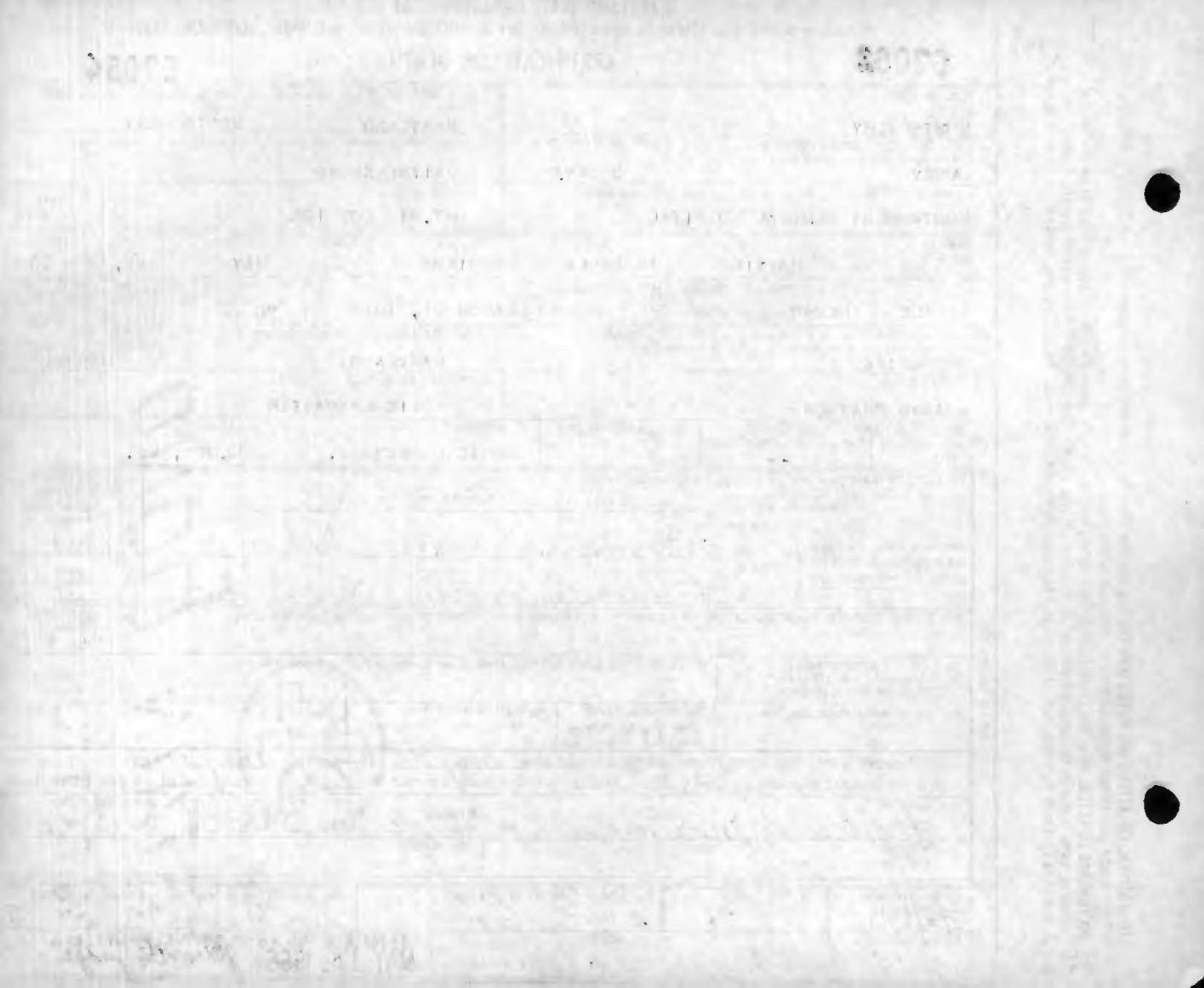
CERTIFICATE OF DEATH

07054

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN lb 3 DAYS	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAIITHERSBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		e. STREET ADDRESS RT. #1 BOX 129		f. DATE OF DEATH MAY 11, 1966		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First HATTIE	Middle ISABELLA	Last ADDISON	Month MAY	Day 11	Year 1966				
S. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1896	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME HOWARD PRATHER		14. MOTHER'S MAIDEN NAME ROSIE LANCASTER								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. --		17. INFORMANT MEDICAL RECORDS,		Address OLNEY, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33xx		DUE TO Ischemia, Brainstem		INTERVAL BETWEEN ONSET AND DEATH 3 days						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Thrombosis, Basilar Artery		DUE TO Atherosclerosis, BA + General Severe		3 days Years.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. May 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Olney	(County) Maryland	(State) MD				
21. I certify that (I) (this hospital) attended the deceased from May 8, 1966 , to May 11, 1966 , that (I) (we) last saw the deceased alive on May 11, 1966 , and that death occurred at M , from causes and on the date stated above.										
22a. SIGNATURE Frederick Moorman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5-12-66					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS								
23a. BURIAL CREMATION, REMAINS (Specify) cremated		23b. DATE THEREOF 5/14/66	23c. NAME OF CEMETERY OR CREMATORIAL Brooke Grove	23d. LOCATION (City or Town) Laytonsville Montg. Md.		(County) Maryland				
24. FUNERAL DIRECTOR Robert L. Snowden Rockville, Md		ADDRESS		25a. SIGNED BY REGISTRAR MAY 18, 1966	25b. REGISTRAR'S SIGNATURE Robert L. Snowden Judge					



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

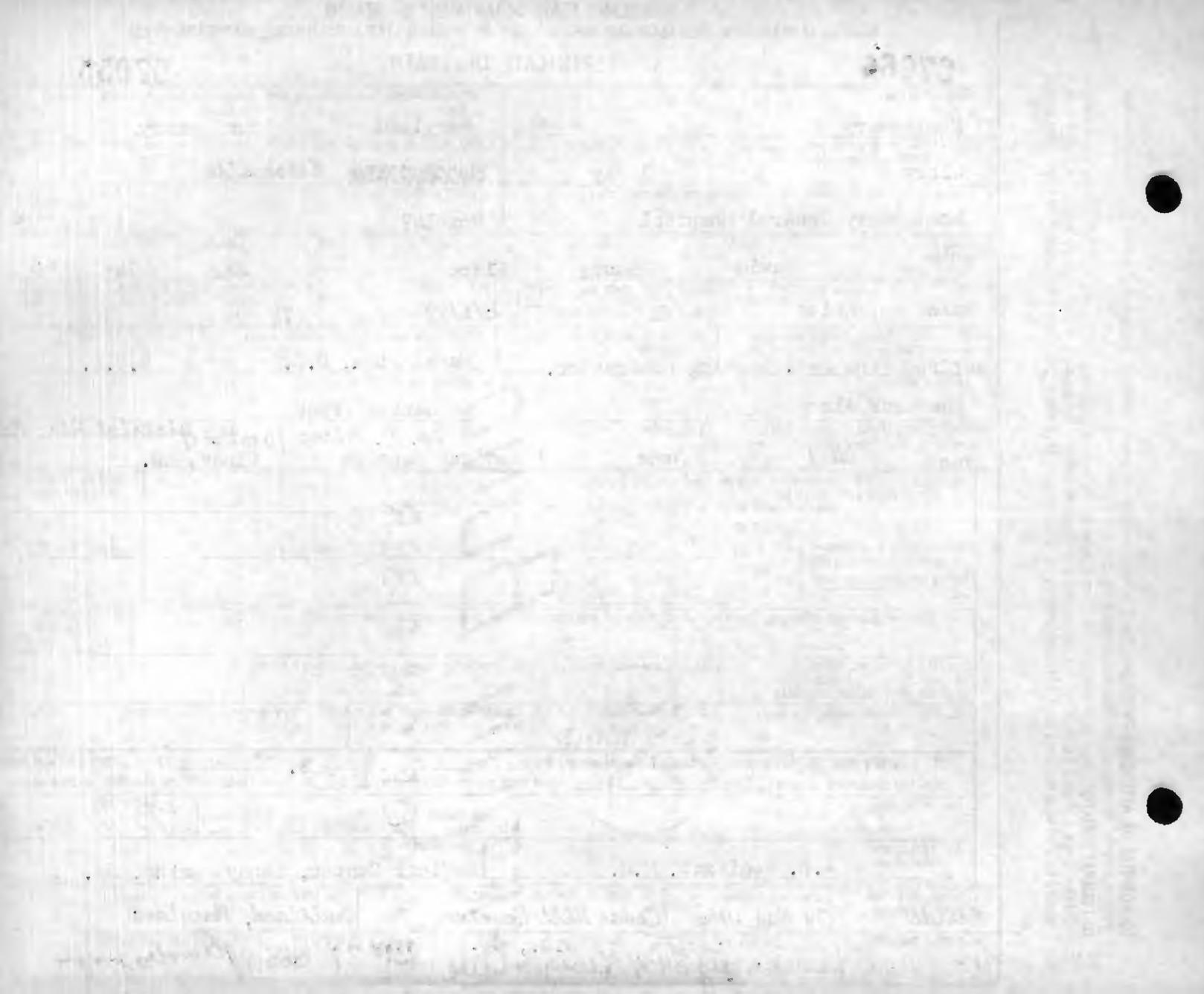
CERTIFICATE OF DEATH

07055

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Montgomery Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		b. COUNTY Brookville 15-1	
c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS Box 147	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First David	Middle Henry	Last Alsop
4. DATE OF DEATH	Month May	Day 24	Year 19 66
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 4/1/92	9. AGE (In years less birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber & heating contractor.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thaddeus Alsop	14. MOTHER'S MAIDEN NAME Catherine Frank		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes <i>WWI</i>	16. SOCIAL SECURITY NO. None	17. INFORMANT <i>Wm. J. Alsop (brother)</i> Address Medical Records District Hts. Md. Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Apoplexia, hemiplegia</i> DUE TO 443.8			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>very complete left hemiplegia</i> DUE TO (c) <i>Hypertension caused sudden</i> DUE TO			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Medical Center
(City or town) Sandy Spring, Md.		(County) Montgomery	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from May 23, 1966 , to May 24, 1966 , that (I) (we) last saw the deceased alive on May 24, 1966 , and that death occurred at 10:05M , from causes and on the date stated above.			
22a. SIGNATURE <i>A.D. Bonifant</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) A.D. Bonifant, M.D.		22b. DATE SIGNED 5/24/1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 29 May 1966	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATION (City or Town) Suitland, Maryland
(County) Montgomery	(State) Md.		
24. FUNERAL DIRECTOR <i>Cliff Carter</i>	ADDRESS S.S., Md. Warner E. Humphrey 8434 Georgia Ave.	25. RECEIVED BY REGISTRAR DATE MAY 27 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07065

CERTIFICATE OF DEATH

07056

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 <i>Silver Spring</i>		b. COUNTY <i>Montgomery</i>	
c. LENGTH OF STAY IN 1b <i>1 mon/5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hosp. of Silver Spring</i>		d. STREET ADDRESS <i>9424 Curran Rd</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month Day Year <i>May 2 1966</i>	
3. NAME OF DECEASED (Type or print) <i>Clarence C. Andrews</i>		4. LAST	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/5/13</i>	
9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>53 yrs.</i>		10. KIND OF BUSINESS OR INDUSTRY <i>9.9.7 Communications Satellite Rx.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Electrical Technician</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles E. Andrews</i>		14. MOTHER'S MAIDEN NAME <i>Anna Kersler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>171 05 9362</i>	
17. INFORMANT <i>C. Katherine Andrews Silver Spring, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute hemorrhagic pancreatitis</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>576X</i> (b) <i>Retroperitoneal hemorrhage</i> DUE TO (c) <i>Subdiaphragmatic abscess</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>28 MAR 1966</i> to <i>2 MAY 1966</i> , that (I) last saw the deceased alive on <i>2 MAY 1966</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>3 MAY 66</i>	
22a. SIGNATURE <i>Richard Compton</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>J. RICHARD COMPTON</i>		22d. ADDRESS <i>612 MAIN ST, LAUREL, MD.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 6, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Geo. Wash. Memorial Park</i>		23d. LOCATION (City, town or county) (State) <i>Paramus, New Jersey</i>	
24. FUNERAL DIRECTOR <i>Warren E. Pumphrey, Inc.</i>		ADDRESS <i>4120 Georgia Avenue N.W. Washington, D.C. 20014</i>	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1 M
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07057

07066		Items 10a, 10b, 11, 13, 14		07057	
1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
Montgomery Buck Hill		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. STATE	
Maryland		c. LENGTH OF STAY IN 1b		Virginia	
D.O.A		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Suburban		3701 So. 5th St. # 504		d. STREET ADDRESS	
79		e. IS RESIDENCE ON A FARM?		e. DATE OF DEATH	
m		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5	Month Day Year
3. NAME OF DECEASED (Type or print)		First	Middle	Last	30 1966
Ray Carson Bailey					
4. SEX		5. COLOR OR RACE	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH
m		law			8/20/19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Unk. Auditor		Interstate		Onaway, Mich.	
13. FATHER'S NAME		Unk. Department Stores		12. CITIZEN OF WHAT COUNTRY?	
Unknown Earl Bailey				USA	
14. MOTHER'S MAIDEN NAME		Mable Glenn Byrd			
Mrs. J. Torrance		Address 3701 S. 5th St.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
See Marines		WW 1 566-12-6996		Mrs. Lt. Col. Mildred C. Bailey Arlington, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries multiple, severe		8234			
DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		(b) Automobile accident		xx0xx0xx	
DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Car went out of control on highway 495.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour p.m. 8:30 5/30 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) (County) (State) Bethesda Mont. Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John E. Bell		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 5/31/66	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/66		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem., Arlington, Virginia	
24. FUNERAL DIRECTOR John C. Thomas		ADDRESS Murphy Funeral Home 3524 Columbia Pike, Arl.		25a. REC'D BY REGISTRAR JUN 3 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 4 may be retained by the hospital or attending physician. Then, please remove carbon papers. Pages 1 and 2, director, page 3, should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2, director, page 3, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

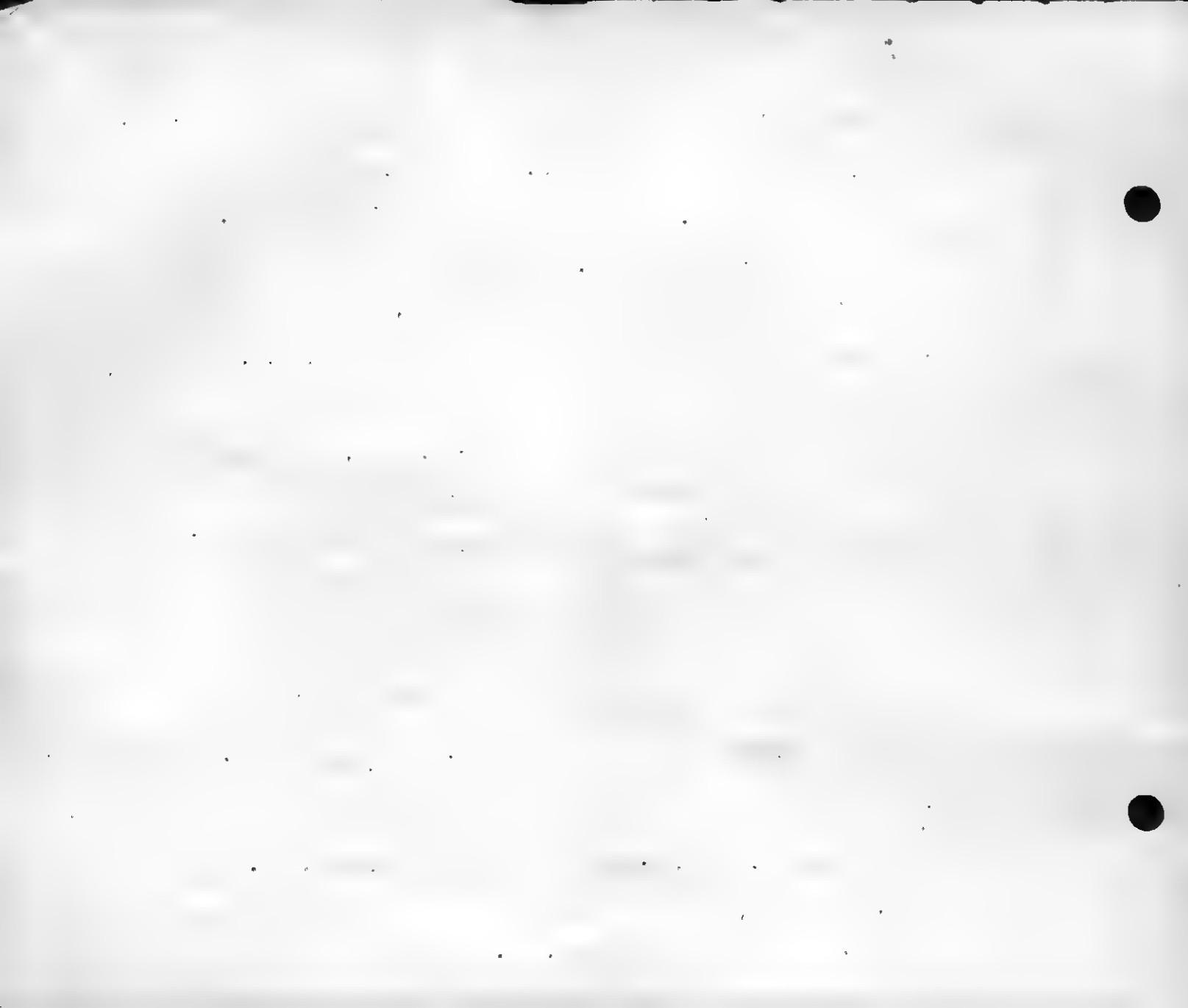
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7067

CERTIFICATE OF DEATH

07058

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Damascus		c. LENGTH OF STAY IN lb 14 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 26613 Ridge Rd.		e. STREET ADDRESS 26613 Ridge Rd.	
3. NAME OF DECEASED (Type or print) Nettie I. Balderson		First Nettie	Middle I.
4. DATE OF DEATH May 27 1966		Last Balderson	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 10, 1879		9. AGE (in years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Parishville, N.Y.
13. FATHER'S NAME Emory Hall		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Jerry L. Cook, Item 2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4/22/1 DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 week			
10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Damascus, Md.
20f. (City or town) (County) (State)			
21. I certify that (I) James P. Kerr, M.D. attended the deceased from 4/18 1966 to 5/27 1966, that (I) last saw the deceased alive on 5/23 1966, and that death occurred at 8:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE James P. Kerr, M.D.		22b. DATE SIGNED 5/28/66	
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.		22d. ADDRESS Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 1, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Oakwood		23d. LOCATION (City, town or county) (State) Theresa, New York	
24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DATE JUN 2 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			37059				
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland Wash. D.C. Montgomery</i>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. LENGTH OF STAY IN 1B <i>6 days</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>1656 Park Road, N.W.</i>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy CROSS Hosp.</i>				d. STREET ADDRESS <i>Washington, D.C.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <i>Marguerite</i>	Middle <i>E. M.</i>	Last <i>BANNON</i>	4. DATE OF DEATH Month <i>MAY</i>	Day <i>8</i>	Year <i>1966</i>												
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-23-95</i>	9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <i>canada</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KING OF BUSINESS OR INDUSTRY				11. MOTHER'S MAIDEN NAME <i>Margaret Regan</i>											
13. FATHER'S NAME <i>Robert Williamson</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Regan</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>ms. E. Francella</i>				17. INFORMANT daughter			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				19. INTERVAL BETWEEN ONSET AND DEATH															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i>				DUE TO (b)				6 days											
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>Colonary Occlusion</i>				DUE TO (c)				6 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized Atherosclerosis</i>								6 days				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>White at work</i>				20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Not White at work</i>				20f. (City or town) (County) (State)							
20e. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED <i>5/2/66</i>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5/2/66</i>				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>5/2/66</i> to <i>5/8/66</i> , that (I) (we) last saw the deceased alive on <i>5/8/66</i> , and that death occurred at <i>5/8/66</i> from the causes and on the date stated above.								22a. SIGNATURE <i>John J. Curry</i>				22b. DATE SIGNED <i>5/8/66</i>							
22c. PHYSICIAN'S NAME (Type) <i>JOHN J. CURRY</i>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS <i>10620 Georgia Ave. N.E.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE THEREOF <i>12 MAY 1966</i>				23c. NAME OF CEMETERY OR CREMATORIUM <i>GATE OF HEAVEN CEMETERY</i>				23d. LOCATION (City, town or county) (State) <i>SILVER SPRING MD.</i>							
24. FUNERAL DIRECTOR <i>John J. Curry</i>				ADDRESS				25a. REC'D BY REGISTRAR <i>CHARLES JUDGE</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
DATE <i>MAY 10 1966</i>																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

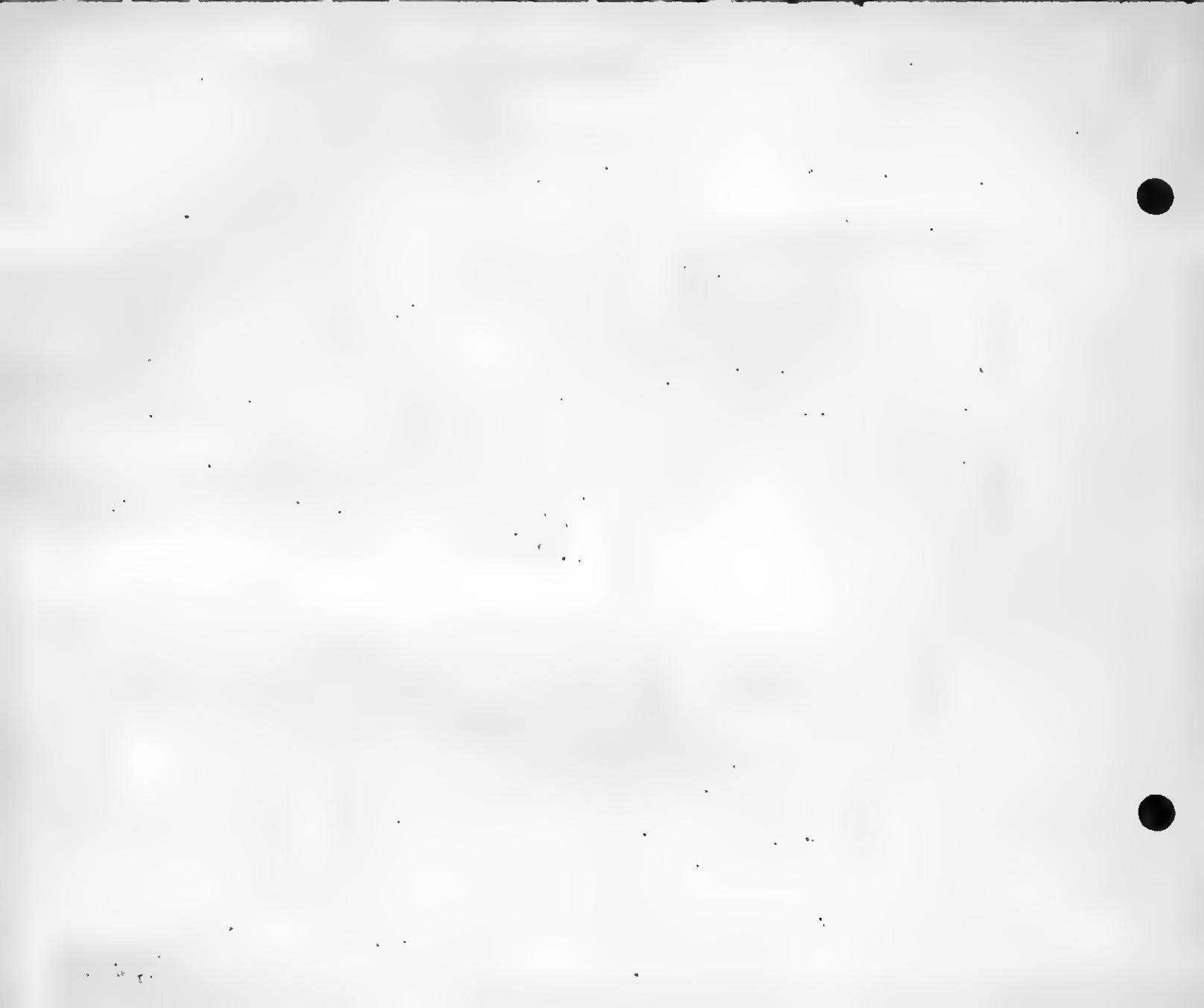
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1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH WILLIAM F. BARNUM

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN lb 3 DAYS.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SANITARIUM		e. STREET ADDRESS 22 GRANT AVE	
3. NAME OF DECEASED (Type or print) WILLIAM FREDERICK BARNUM		First W	Middle F
4. DATE OF DEATH 11-9-66		Month 5	Day Year 1 1966
5. SEX M		6. COLOR DR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11-9-84		9. AGE (in years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months 5
10b. KIND OF BUSINESS OR INDUSTRY SAVAGE (retired)		11. BIRTHPLACE (County & State, or foreign country) NY.	12. CITIZEN OF WHAT COUNTRY? AMER.
13. FATHER'S NAME WILLIAM BARNUM		14. MOTHER'S MAIDEN NAME MARY SLATER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 05-12	17. INFORMANT Child
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute myocardial infarction Senile Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 10 yrs.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1946 , 19 to 3/1/66 , 19, that (I) (we) last saw the deceased alive on 4/30/66 , 19, and that death occurred at NOVA M. from the causes and on the date stated above.		22b. DATE SIGNED 3/1/66	
22a. SIGNATURE H.B. Queen		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS 7112 Carroll Ave
22c. PHYSICIAN'S NAME (Type) H.B. Queen		23d. LOCATION (City, town or county) Colmar Manor	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF May 4, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery
24. FUNERAL DIRECTOR J. Arthur Walters, 254 Carroll NW, DC		ADDRESS 25a. REC'D BY REGISTRAR DATE MAY 4 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 821 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		e. STREET ADDRESS 1729 Lamont Street, N.W.	
3. NAME OF DECEASED (Type or print) First Lee Middle Kirby Last Barrett		4. DATE OF DEATH Month May Day 28 Year 1966	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 28 May 1926	
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gambler		10b. KIND OF BUSINESS OR INDUSTRY Gambling	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel M. Barrett		14. MOTHER'S MAIDEN NAME Hilda Kirby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unobtainable	
17. INFORMANT The Medical Record		Address Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoventilation		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Amyotrophic Lateral Sclerosis 4 years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (b) (this hospital) attended the deceased from Feb. 27, 1964 , to May 28, 1966 , that (b) (we) last saw the deceased alive on May 28, 1966 , and that death occurred at 9:00M . From the causes and on the date stated above.			
22a. SIGNATURE Jon D. Dorman		22b. DATE SIGNED P.M.	
22c. PHYSICIAN'S NAME (Type) Jon D. Dorman, MD.		ATTENDING M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE THEREOF 5/31/66	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR The S.H. Hines Company		ADDRESS Washington, D.C.	
25a. REC'D BY REGISTRAR JUN 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



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Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7071

CERTIFICATE OF DEATH

37062

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Nursing Home	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MATTIE	First MATTIE	Middle 	Last BARTLE	4. DATE OF DEATH 114 19 1966	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?	9. AGE (In years last birthday) 96 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charles P. Jones	14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address Wm. J. Bartle 329 Md. Ave. D. C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 14X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ESSENTIAL HYPERTENSION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS				INTERVAL BETWEEN ONSET AND DEATH — — —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) SENILITY				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JUNE 19, 1961 , to 114 19, 1966 , that (I) (we) last saw the deceased alive on MAY 19 1966 , and that death occurred at 5:30 M , from the causes and on the date stated above.					
22a. SIGNATURE <i>Henry M. Lowden</i>	22b. DATE SIGNED 5/19/66				
22c. PHYSICIAN'S NAME (Type) Henry M. Lowden	M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 5206 Norway Dr. Chevy Chase, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 5/19/66	23c. NAME OF CEMETERY OR CREMATORIAL Lee's	23d. LOCATION (City, town or county) (State) Washington, D.C.		
24. FUNERAL DIRECTOR Lee Funeral Home	25a. REC'D BY REGISTRAR MAY 23 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

C7072

CERTIFICATE OF DEATH

C7063

10 HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>D.C.</i>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		b. COUNTY	
c LENGTH OF STAY IN lb		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>wash. D.C.</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash San. & Hospital</i>		d STREET ADDRESS <i>7630 - 9th St. n.w.</i>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <i>Clara</i>	Middle <i>Ann</i>	Last <i>Belkov</i>
4 DATE OF DEATH Month <i>5</i>	Month <i>May</i>	Day <i>26</i>	Year <i>1966</i>
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>5-15-95</i>
9. AGE (In years last birthday) yrs <i>71</i>	10a. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11 BIRTHPLACE (County & State or foreign country) <i>Baltimore, Md</i>	12 CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Morris Fishler</i>	14. MOTHER'S MAIDEN NAME <i>Lena</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <i>No</i>	
16. SOCIAL SECURITY NO <i>225-07-5685</i>		17. INFORMANT <i>Hus. Mr Sol Belkov</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>	
4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arteriosclerotic Heart Disease</i>		DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>			
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 22, 1963</i> , to <i>May - 26, 1966</i> , that (I) (we) last saw the deceased alive on <i>April 18, 1966</i> , and that death occurred at <i>11:00 A.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Benjamin Lissman, M.D.</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>5/26/66</i>
22c. PHYSICIAN'S NAME (Type) <i>Benjamin Lissman M.D.</i>		22d. ADDRESS <i>2733 Alaska Ave N.W. Wash. D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>5-19-66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>North Mem. Park</i>	23d. LOCATION (City or Town) (County) (State) <i>Foggy Bottom</i>
24. FUNERAL DIRECTOR <i>GODFREY FUNERAL HOME 4212 9th Street</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>JUN 1 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Gray</i>



1
FOR STATE
HEALTH DEPT.

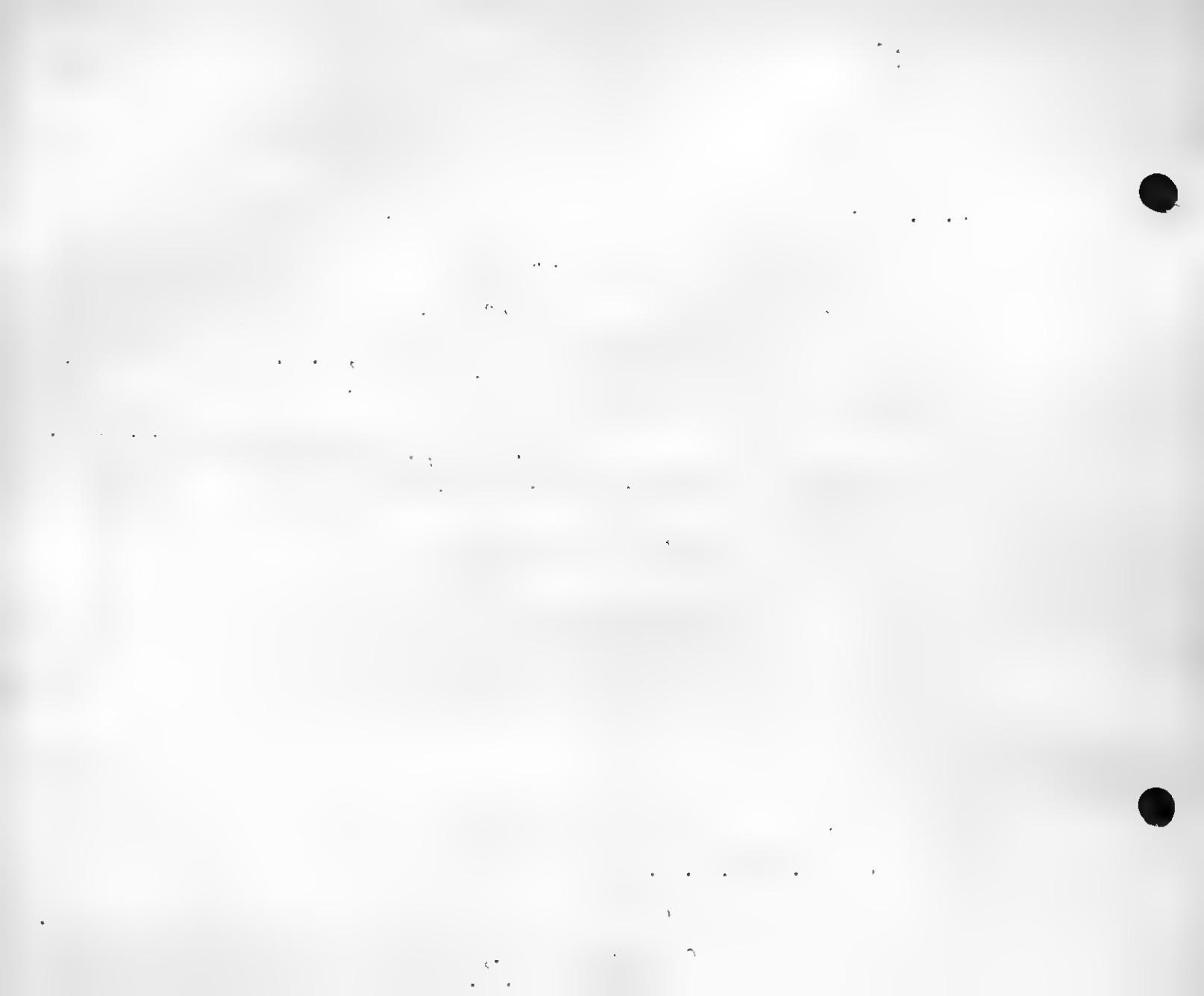
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louise Marie BERNARD		First Louise	Middle Marie
Last BERNARD		Last BERNARD	4. DATE OF DEATH May 27
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH June 18, 1892	9. AGE (In years from birth date) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker	10b. KIND OF BUSINESS OR INDUSTRY Fabric manufacturing	11. BIRTHPLACE (State or foreign country) Providence, R. I.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Ernest Bizat		14. MOTHER'S MAIDEN NAME Erima Larnee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Frank L. Arnold, 4949 Battery Lane	
Address Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Coronary arteriosclerosis (c) DUE TO Coronary insufficiency acute		INTERVAL BETWEEN DEATH AND DEATH sudden years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Silver Spring
20f. (City or town) Silver Spring		(County) Maryland	
(State) Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and In my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John G. Ball, M. D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		22. DATE SIGNED 27 May 1966	
23a. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) Burial 15/31/66			
23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery		23d. LOCATION (City, town or county) Silver Spring	
24. FUNERAL DIRECTOR Chevy Chase Funeral Home 5103 Wisconsin Ave., NW Washington, D. C.		(State) Maryland	
ADDRESS 127 Jefferson		25a. REC'D BY REGISTRAR JUN 3 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. ■■■ 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07074

CERTIFICATE OF DEATH

07065

1. PLACE OF DEATH COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton			b. COUNTY Prince Georges County		
c. LENGTH OF STAY IN 1b 6 ½ mos.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home			d. STREET ADDRESS Building 4, Apt. 301 5601 Parker House Terrace		
3. NAME OF DECEASED (Type or print) Jennie Bernstein (no middle name)			4. DATE OF DEATH Month 5/23/ Year 1966		
S SEX Female	6 COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/11/1871	9. AGE (In years last birthday) 94 yrs
10a. U.S. AI OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-factory worker			10b. KIND OF BUSINESS OR INDUSTRY Poland		
11. BIRTHPLACE (County & State, or foreign country) Poland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME (last name changed to Bernstein) Abraham Boraso			14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO none		
17. INFORMANT Ethel Krawitz, see 2 above			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Concussion of Spine and brain</i>			INTERVAL BETWEEN ONSET AND DEATH <i>several days</i>		
151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>loss of life</i>					
DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Malignant tumor</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 1, 1964 , to May 22, 1966 , that (I) (we) last saw the deceased alive on May 22, 1966 , and that death occurred at 1712-I-S, L.A., WASH C, D.C. M, from causes and on the date stated above.					
22a. SIGNATURE <i>Irwin H. Ardam</i>			MD ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5-23-66	
22c. PHYSICIAN'S NAME (Type) Irwin H. Ardam			22d. ADDRESS 1712-I-S, L.A., WASH C, D.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-27-66	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Maspeth, L.I., N.Y.	
24. FUNERAL DIRECTOR <i>Gillberg Funeral Home - 4217-7th St. NW</i>		ADDRESS	25a. REC'D BY REGISTRAR MAY 31 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
VR A15 (4) 20 M 1/66					



1

FOR STATE
HEALTH DEPT.

M

Item 18b Film G378 6/2006

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7075

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7066

Item 1d Film G377

1. PLACE OF DEATH

e. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Kenwood Golf & Country Club

U.S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)First
HaroldMiddle
W.Last
Blakeley4. DATE
OF
DEATHMonth
May 10Year
1966

5. SEX

Male

6. COLOR OR RACE

Cauc.

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

12-29-1893

9. AGE (In years
last birthday)72
yrs.10. IF UNDER 1 YEAR
MONTHS

Days

11. IF UNDER 24 HRS.
Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

U. S. Army

10b. KIND OF BUSINESS OR
INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Massachusetts

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

John Blakeley

14. MOTHER'S MAIDEN NAME

Carrie Skinner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) ((If yes give war or dates of service))

Yes

16. SOCIAL SECURITY NO.

579-48-0763

17. INFORMANT

Address

See Item No. 2.
Louise deL. Blakeley

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary insufficiency, acute

INTERVAL BETWEEN
ONSET AND DEATH
sudden

4201

Conditions, If any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

DUE TO

Hypertensive
Cardiovascular disease

DUE TO

(b)

(c)

Cardiovascular disease

years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ACTUAL
SIGNATURE

John E. Bree

CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 22. DATE SIGNED
May 10, 1966EXAMINER'S
NAME (Type)

John G. Ball, M. D.

Address (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 5-12-1966 Arlington National Cemetery, Arlington, Virginia

ADDRESS

23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORIAL
Joseph Gowler & Sons, 5130 Wisconsin Ave., N.W.
Washington, D.C.

23d. LOCATION (City, town or county)

(State)

25a. REC'D BY REGISTRAR

25d. REGISTRAR'S SIGNATURE

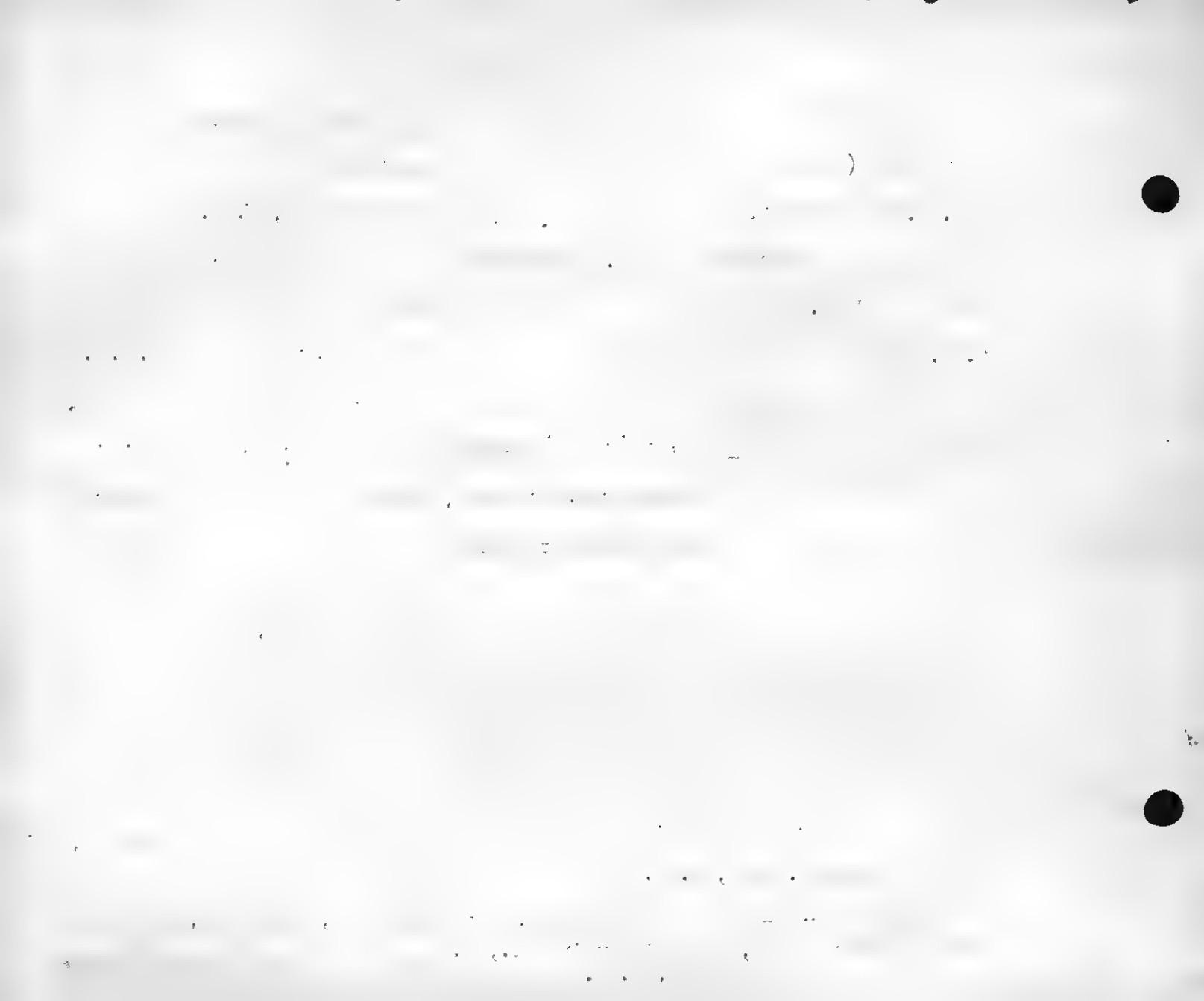
DATE

MAY 13 1966

CHARLES JUDGE

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 to the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												07067											
CERTIFICATE OF DEATH																							
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE																			
Montgomery				Maryland								Montgomery											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb								c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)											
Rockville												Rockville											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
503 Woodburn Rd.				503 Woodburn Road																			
3. NAME OF DECEASED (Type or print)		First		Middle		4. DATE OF DEATH		Month		Day		Year											
Bertha		Mae		Blankenship		MAY		3		1966													
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.											
F		Wh		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		May 16, 1903		62 yrs.		11 months		11 days		17 hours									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?											
Housewife								West Virginia				U.S.A.											
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				Address															
Joseph Wolfe				Sarah Cannoy				Henry B. Blankenship same item #2 - Husband															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
No												PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
												Septicemia											
												INTERVAL BETWEEN ONSET AND DEATH 2-4 days											
												2 yrs.											
												3 1/2 yrs											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
												19 1966											
21. I certify that (I) (this hospital) attended the deceased from Jun 1965 to 5/3 1966, that (I) (we) last saw the deceased alive on 5/2 1966, and that death occurred at 2:30 PM, from the causes and on the date stated above.																22a. SIGNATURE G. Lennard Gold							
																				22b. DATE SIGNED 5/3/66			
22c. PHYSICIAN'S NAME (Type)				23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION (City, town or county) (State)							
G. Lennard Gold				Burial				May 6, 1966				Parklawn				Rockville, Maryland							
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Tyson Wheeler F.H.				1331 Rockville Pike Rockville, Maryland				MAY 5 1966				Charles Judge											
VR A15 (4) 20M 1/65																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
C7877 CERTIFICATE OF DEATH 07068											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland				b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 19 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 10415 Montrose Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Frances	Middle M.	Last Bloodgood	4. DATE OF DEATH May 31 1966	Month May	Day 31	Year 1966			
5. SEX F		6. COLOR OR RACE W	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1878	9. AGE (In years last birthday) 87 yrs.	10. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (County & State, or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Frank Mason	14. MOTHER'S MAIDEN NAME Montague
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT None		Address Bethesda, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cocaine & Heroin Defects</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Cocaine & Heroin Defects</i> (c) <i>years</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cocaine Heart Failure - Olegone</i>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frances Lusby, 10415 Montrose Ave.		(County) Bethesda		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 4-1-66 to 5/30 1966 , that (I) (we) last saw the deceased alive on 5/30 1966 , and that death occurred at 4-1-66 M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Iruin H. Ardman</i>		22b. DATE SIGNED 5-31-66									
22c. PHYSICIAN'S NAME (Type) Iruin Ardman		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-2-1966		23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) Prince Georges Co. Md.					
24. FUNERAL DIRECTOR Joseph Shuler & Sons		ADDRESS		25a. REC'D BY REGISTRAR JUN 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 (4) 20M 1/65											



1 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

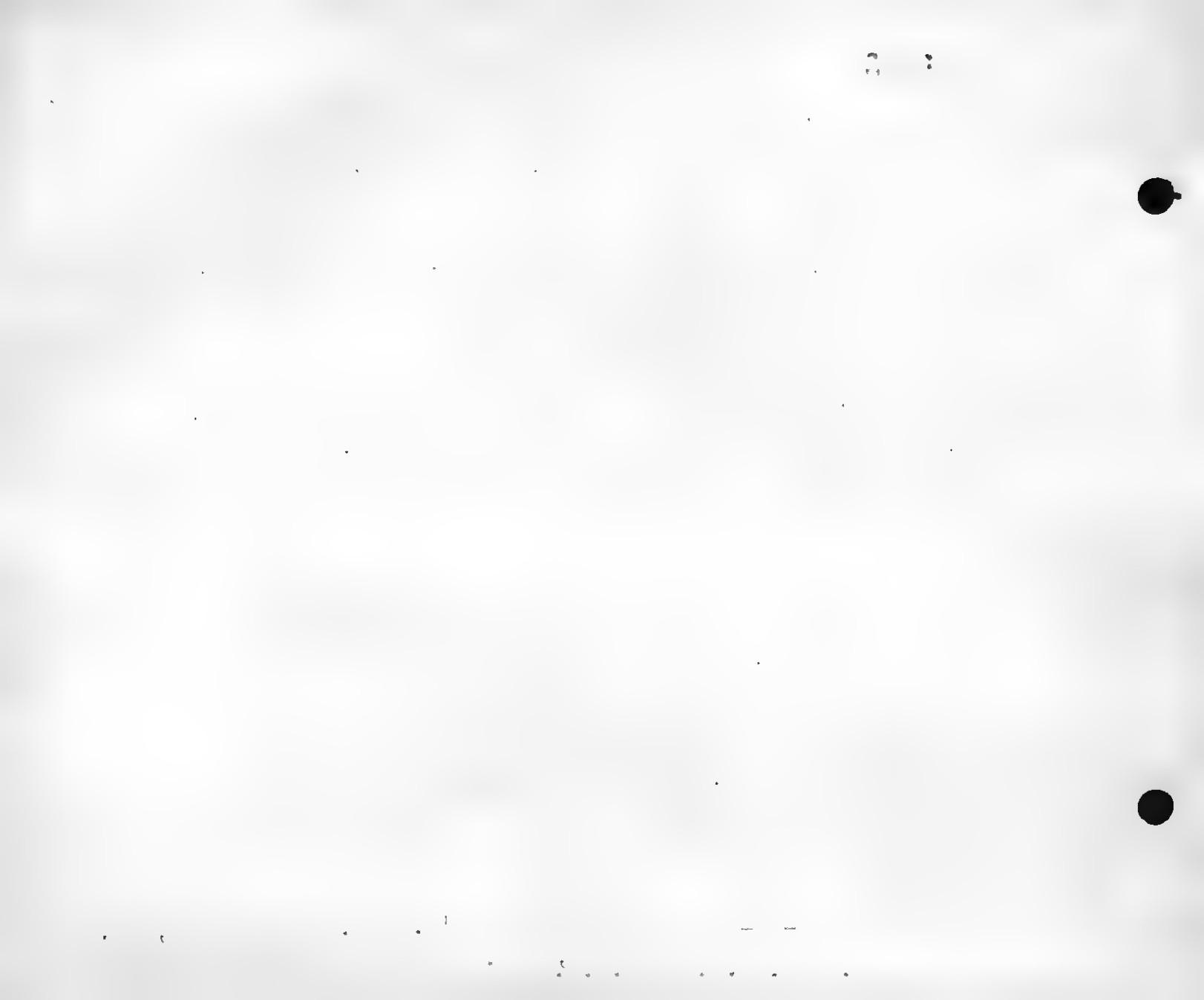
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07983

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>9 days</i>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Sababaugh</i>			d. STREET ADDRESS <i>5511 JOHNSON AVE.</i>		
3. NAME OF DECEASED First <i>Marie</i> Middle <i>K. Bonny Castle</i> Last			4. DATE OF DEATH <i>May 18 1966</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12/2/79</i>	9. AGE (in years last birthday) <i>86 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. US. AL OCC. PATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Kentucky</i>	
13. FATHER'S NAME <i>Logan P Kennedy</i>		14. MOTHER'S MAIDEN NAME <i>Sophia L. Lettgow</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) Mrs. Robert H. Beall, Bethesda, Md.	
IMMEDIATE CAUSE (a)		DUE TO <i>Bronchopneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pathologic fracture (R) hip; Metastatic Carcinoma</i>					
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m. <i></i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Arlington</i> (County) <i>Montgomery</i> (State) <i>Md</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>5-9 1966</i> , to <i>5-18 1966</i> , that (II) (we) last saw the deceased alive on <i>5-17 1966</i> , and that death occurred at <i>11:00 A.M.</i> from causes and on the date stated above.					
22a. SIGNATURE <i>Donald L. Bucy</i>		22b. DATE SIGNED <i>5-18-66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Donald L. Bucy</i>		22d. ADDRESS <i>809 Veirs Mill Rd Mont. Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-23-1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Nat'l. Cem.</i>	23d. LOCATION (City or Town) <i>Arlington</i> (County) <i>Va</i> (State)	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		ADDRESS <i>5130 Wisc. Ave. N.W. Wash.D.C.</i>	25a. REC'D BY REGISTRAR <i>MAY 23 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please attach one carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and if any event, within 72 hours after death.

C7073

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

27069

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Brentwood WHEATON

c. LENGTH OF STAY IN lb

18mos

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Wheaton Nursing Home

e. NAME OF DECEASED First

Margaret

f. SEX

g. COLOR OR RACE

h. MARRIED

i. EVER MARRIED

j. WIDOWED

k. DIVORCED

l. B. DATE OF BIRTH

m. DATE 2 1868

n. AGE (In years last birthday)

o. IF UNDER 1 YEAR Months

p. IF UNDER 24 HRS. Days

q. HOURS

r. M.N.

s. FATHER'S NAME

Lebius Kunkle

t. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

u. 16. SOCIAL SECURITY NO

v. INFORMANT

w. 17. ADDRESS

x. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

y. PART I. DEATH WAS CAUSED BY:

z. IMMEDIATE CAUSE (a)

aa. DUE TO

bb. CONDITIONS, IF ANY, WHICH

cc. GAVE RISE TO IMMEDIATE CAUSE

dd. (a), STATING THE UNDERLYING

ee. CAUSE (b)

ff. DUE TO

gg. (c)

hh. DUE TO

ii. (c)

jj. DUE TO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

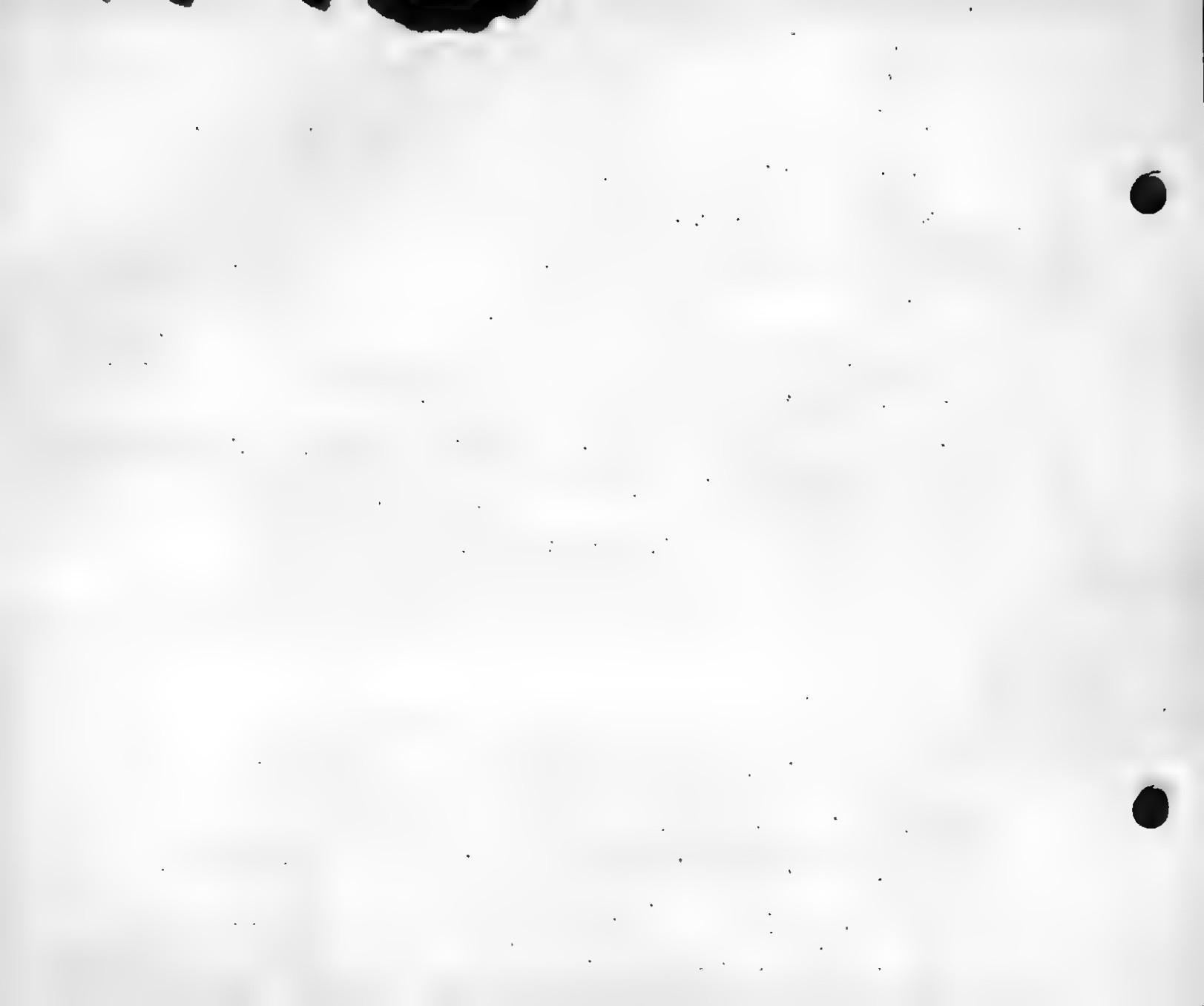
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

37080

CERTIFICATE OF DEATH

37070

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL		d. STREET ADDRESS 8912 FAIRVIEW ROAD	
3. NAME OF DECEASED (Type or print) GEORGE		First (NMN)	Middle BRANDT
Last BRANDT		Month MAY	Day 8
4. DATE OF DEATH DEC 1, 1882		Year 1882	Day 1966
5. SEX Male		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET MAKER		10b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop	
11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Heinrick Brandt		14. MOTHER'S MAIDEN NAME ? Kammer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-01-5644	
17. INFORMANT Walter W. Brandt Hospital Records		Address 1415 Stateside Dr. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause, per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 6 days	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b). Hypertension		4 years	
(c).			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. May 8		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this-hospital) attended the deceased from Dec 1, 1958 , to May 8, 1966 , that (I) (we) last saw the deceased alive on May 8, 1966 , and that death occurred at 5:25 PM , from the causes and on the date stated above.		22b. DATE SIGNED 5-8-66	
22a. SIGNATURE John N. Andrews		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) John N. Andrews		22d. ADDRESS Rockville Rd Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11 May 1966	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Parklawn Cemetery 8434 Georgia Avenue		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR John E. Phillips Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE MAY 12 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C7081

CERTIFICATE OF DEATH

07071

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

3 yrs

c. LENGTH OF STAY IN lb

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

d. STATE

District of Columbia

e. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Bethesda-Silver Spring NursingHome 3284 Aberfoyle Pl., N.W.

3. NAME OF
DECEASED
(Type or print)First
ETHELMiddle
LLast
BRANSON4. DATE
OF
DEATH

5

14

19 66

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

 WIDOWED

NEVER MARRIED

DIVORCED

8. DATE OF BIRTH

Sept. 23, 1882

9. AGE (In years
last birthday)

83

yrs

10. IF UNDER 1 YEAR

7

Months

21

Days

Hours

Min.

10a. USUA. OCCUPATION (Give kind of work done
during most of working life even if retired)

Housewife

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

Maryland

12. CITIZEN OF WHAT
COUNTRY?

U. S.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO

Unknown

17. INFORMANT

Son
Bruce S. Branson, Jr.Address
Same as Item 2.

18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (o)

332X

CEREBRAL THROMBOSIS

INTERVAL BETWEEN
ONSET AND DEATH
2 weeks

DUE TO

Conditions, if any, which gave
rise to immediate cause (o),
stating the underlying cause
lost

(b)

DUE TO

(c)

Generalized Arteriosclerosis

years

19. WAS AUTOPSY
PERFORMED?YES NO

Pneumonia, bronchial

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o.m.
p.m. 1920d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or Town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/19, 1966 to 5/14, 1966, that (I) (we) last
saw the deceased alive on 5/13, 1966, and that death occurred at 11:50 A.M. from causes and on the date stated above.

22a. SIGNATURE

G. LENNARD GOLD

M.D. ATTENDING
PHYS MED
DIRECTOR STAFF
PHYS.

22b. DATE SIGNED

5/14/66

22c. PHYSICIAN'S
NAME (Type)

22d. ADDRESS

5641 Colesville Road, Silver Spring

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

5-16-66

23c. NAME OF CEMETERY OR CREMATORIAL

Rock Creek Cemetery

23d. LOCATION (City or Town)
(County) (State)

Washington, D.C.

24. FUNERAL DIRECTOR

ROBERT A. PUMPHREY

ADDRESS

Bethesda, Maryland

25a. RECD BY REGISTRAR

D

25b. REGISTRAR'S SIGNATURE

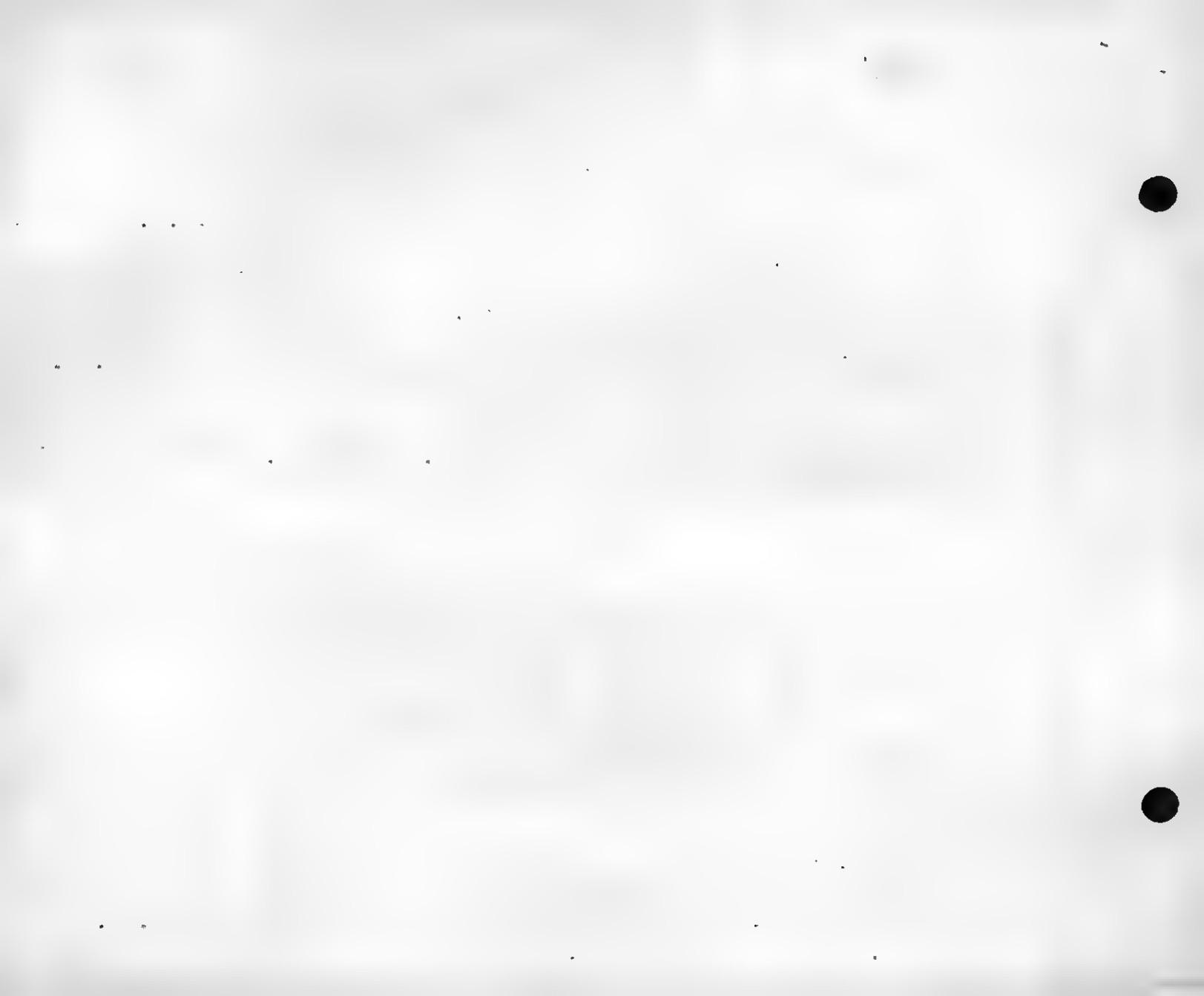
MAY 17 1966

j Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



RE
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or offending physician.

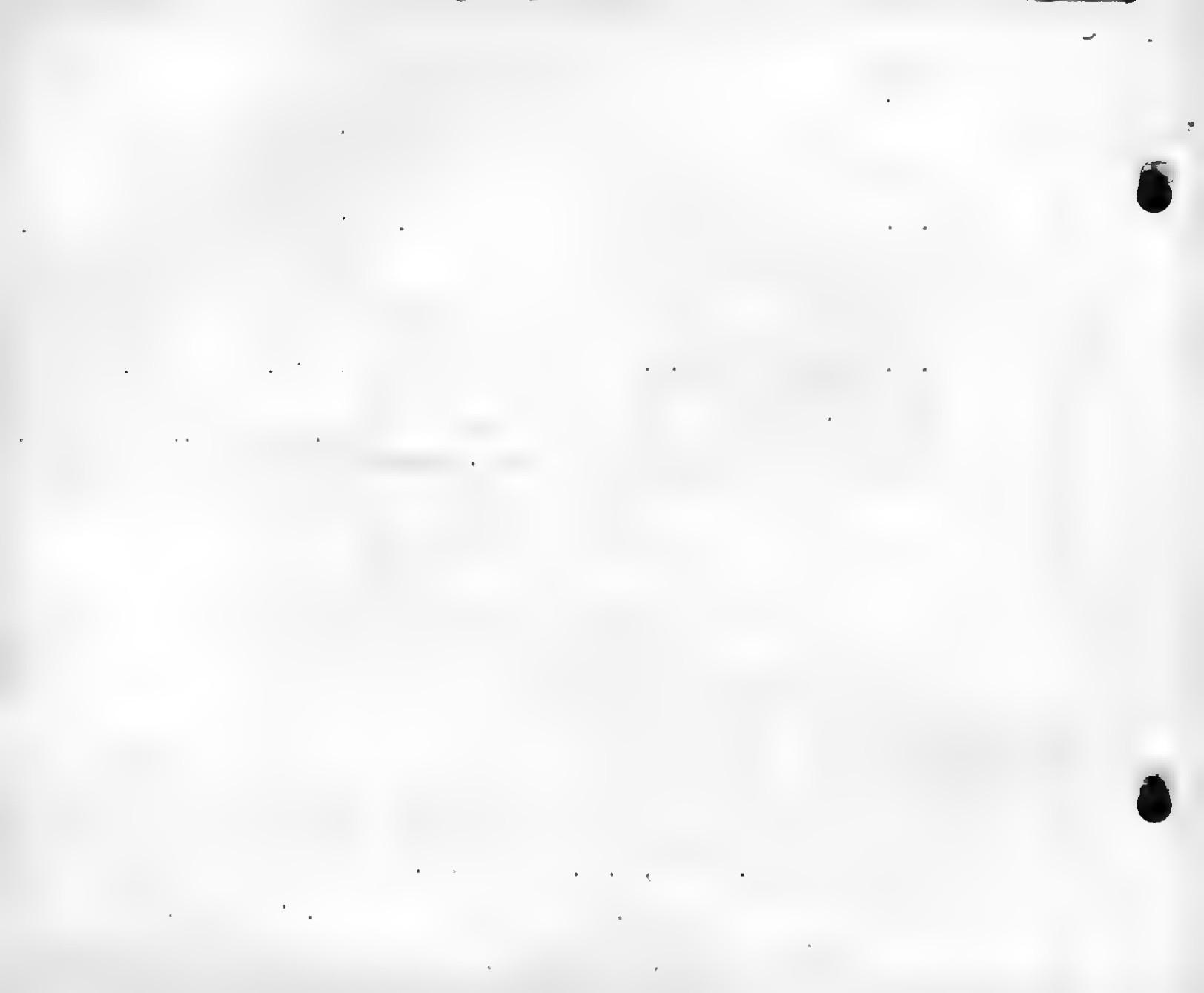
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 23b film G576 5/16/66 mh

CERTIFICATE OF DEATH

07072

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Penn. b. COUNTY Northumberland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda LENGTH OF STAY IN lb 58 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Atlas d. STREET ADDRESS 222 W. Saylor Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) William James BRANZ		First WILLIAM	Middle JAMES
4 LAST BRANZ	5 DATE OF DEATH May 7 1966	6 COLOR OR RACE Cauc.	7 MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8 SEX Male	9 AGE (In years last birthday) yrs 51	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy (Retired)	10b KIND OF BUSINESS OR INDUSTRY U. S. Government
11 BIRTHPLACE (County & State, or foreign country) Conersville, Penn.	12 CITIZEN OF WHAT COUNTRY? USA	13 FATHER'S NAME Modesto J. BRANZ	14 MOTHER'S MAIDEN NAME UNKNOWN
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes	16 SOCIAL SECURITY NO 166-14-3083	17 INFORMANT Mrs. Catherine BRANZ	18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of pancreas with widespread metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1574 (b) Terminal pulmonary embolism DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c TIME OF INJURY Month Day Year Hour o.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9 March 1966 to 7 May 1966 , that (I) (we) last saw the deceased alive on 7 May 1966 , and that death occurred at 1145PM , from causes and on the date stated above.			
22a. SIGNATURE Donald K. Roeder	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 9 May 1966
22c. PHYSICIAN'S NAME (Type) Donald K. Roeder, M. D.	22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		
23a BURIAL, CREMATION, REMOVAL (Check) Burial	23b DATE THEREOF May 12, 1966	23c NAME OF CEMETERY OR CREMATORIUM St. Peters Cemetery	23d LOCATION (City or Town) (County) (State) Mt. Carmel, Pennsylvania
24 FUNERAL DIRECTOR R.A. Pumphrey Funeral Home 7557 Wisconsin Avenue, Bethesda, Md.	25a REC'D BY REGISTRAR Charles Judge	25b REGISTRAR'S SIGNATURE MAY 10 1966	DATE



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C7083

CERTIFICATE OF DEATH

67073

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from papers, pages 1 and 2, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE VIRGINIA b. COUNTY HENRICO ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY	c. LENGTH OF STAY IN lb 8 HRS. 36 MIN.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HIGHLAND SPRINGS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL		d. STREET ADDRESS 508 DALE ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BABY	Middle BOY	Last BRENT
4. DATE OF DEATH 5 24 66	Month	Day	Year 24 19 66
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 5-24-66	9. AGE (In years last birthday) 0 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours 8 Min. 36
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MONTGOMERY COUNTY, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOSEPH MILTON HOFFARTH		14. MOTHER'S MAIDEN NAME REITA SUSAN BRENT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO NONE	17. INFORMANT HOSPITAL RECORDS
		Address OLNEY, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO <i>7625</i> (b) <i>Bilateral pulmonary stenosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>109</i>
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 24 (1 AM) 19 66, to May 24 (4 AM) 19 66 that (I) (we) last saw the deceased alive on May 24 19 66, and that death occurred at 9 45 AM, from causes and on the date stated above.			
22a. SIGNATURE <i>James P. Kerr</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>5/24/66</i>
22c. PHYSICIAN'S NAME (Type) J. P. KERR, M. D.		22d. ADDRESS DAMASCUS, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-25-66	23c. NAME OF CEMETERY OR CREMATORIAL Laytonsville
23d. LOCATION (City or Town) (County) (State)		Laytonsville, Md.	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville, Md.	25d. RECD BY REGISTRAR MAY 27 1966
			25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

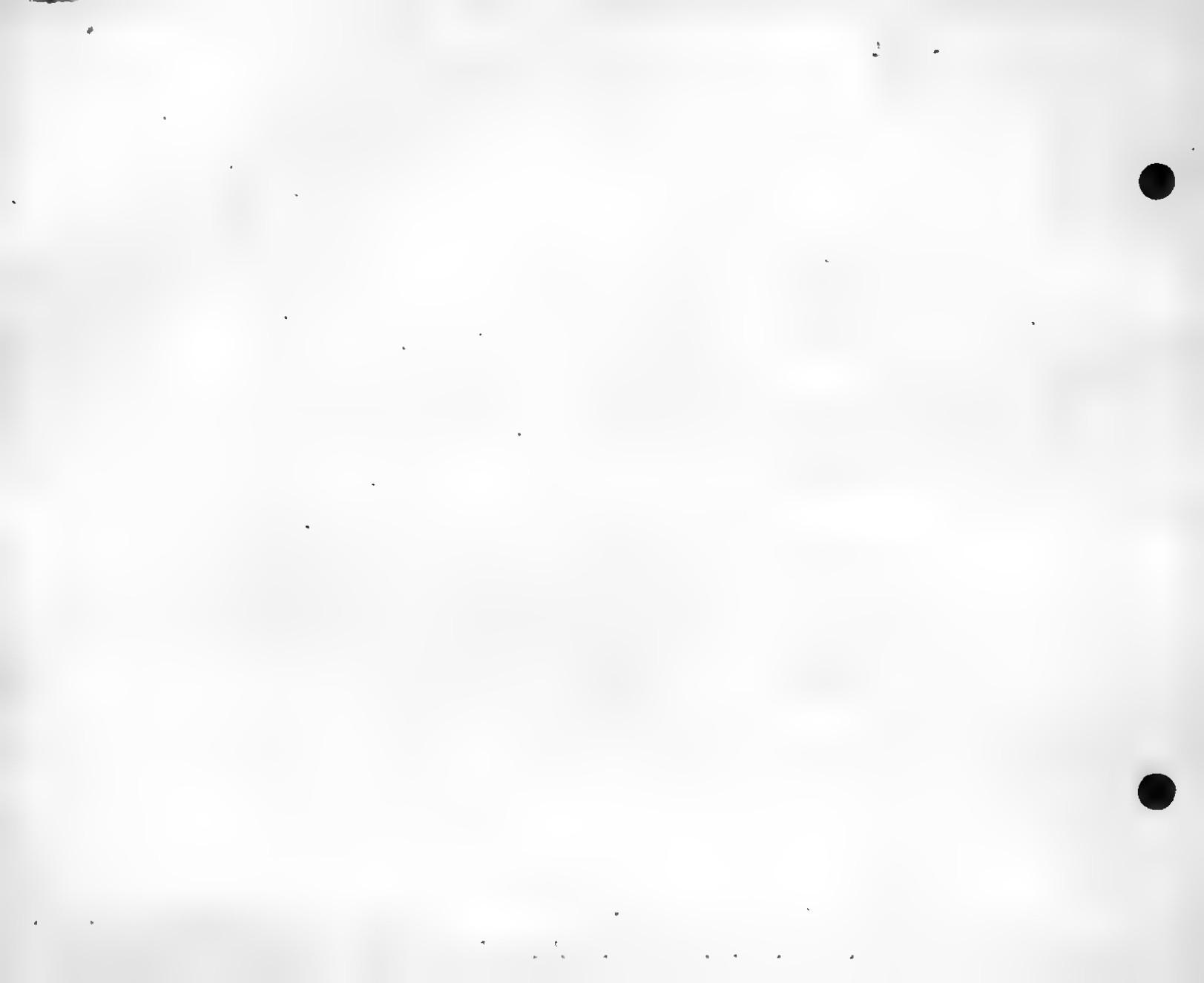


MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers Pages 1 and 2 and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.N
57084

CERTIFICATE OF DEATH

67074

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE				
Montgomery Maryland		Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansington				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS 4407 Franklin St.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3 NAME OF DECEASED (Type or print)	First Agnes	Middle Madden	Last Brew			
4 DATE OF DEATH	5-26-1966	Month	Day Year			
S SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 2-12-79 87 9. AGE (In years birthday) yrs			
10. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		11. BIRTHPLACE (County & State or foreign country) West Virginia				
13. FATHER'S NAME Michael Madden		12. CITIZEN OF WHAT COUNTRY? Catherine Duke				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. None				
17. INFORMANT MRS. Joseph Hockley - 4407 Franklin St. Kensington Md.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) E 18 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN CONSEPT AND DEATH 8 days Generalized arteriosclerosis years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1964	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 5-25-1966, to 5-25-1966, and that death occurred at 9:40 AM, from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22a. SIGNATURE C P Ryland		22b. DATE SIGNED 5-26-66				
22c. PHYSICIAN'S NAME (Type) C P RYLAND		22d. ADDRESS 4407 49 St NW Wash DC				
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5-28-1966		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery		23d. LOCATION (City or Town) Prince Georges Co. Md.
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave. N.W., Wash. D.C.		ADDRESS		25a. REG'D BY REGISTRAR JUN 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7085

07075

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

M

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

WHEATON

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

WHEATON NURSING HOME

3. NAME OF
DECEASED
(Type or print)

First

Middle

4. SEX

F

W

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

WIDOWED DIVORCED

MAR 27 - 1892

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Md.

13. FATHER'S NAME

Thad Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Francis D. Bridgett,

Alexandria, Va.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.
} (b)
DUE TO
(c)

HEPATIC FAILURE

INTERVAL BETWEEN
ONSET AND DEATH

1 MO

19. WAS AUTOPSY PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour
e.m.
p.m.

19

While
at work Not While
at work

factory, street, office bldg., etc.

(City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from..... 1..... 19..... to..... 8..... 19..... that (I) (was) last
saw the deceased alive on 2 May 1966 and that death occurred at 7:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

WALTER GOOZIE MD

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS. 22b. DATE
SIGNED23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

5-12-66

23c. NAME OF CEMETERY OR CREMATORIUM

Cedar Hill

23d. LOCATION (City, town or county)

Suitland, Md.

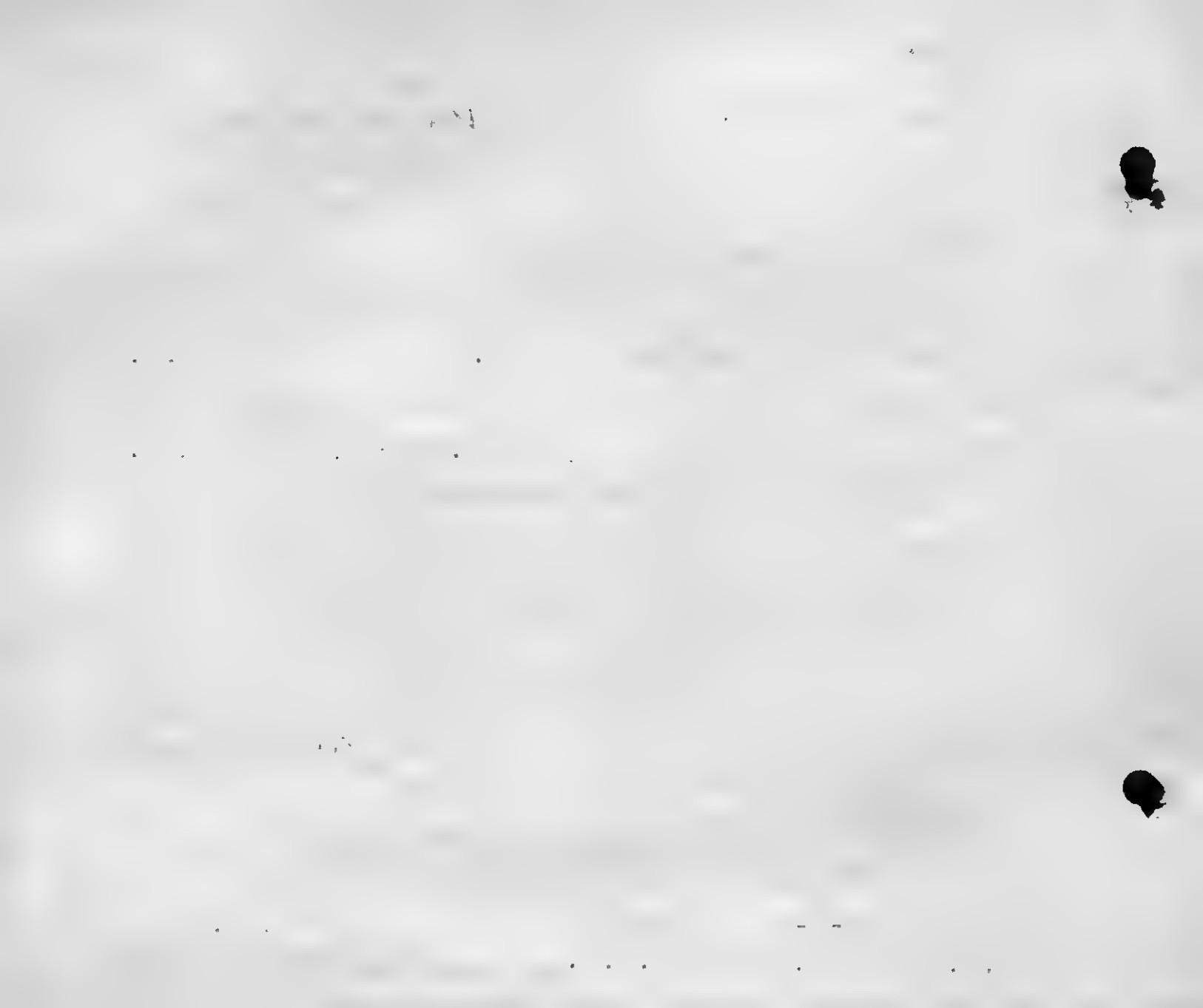
(State)

24 FUNERAL DIRECTOR'S SIGNATURE

W. W. Chambers Co. 517 11th St. S. E.

ADDRESS

25a. REC'D BY REGISTRAR
MAY 11 196625b. REGISTRAR'S SIGNATURE
Charles Judge



1 M

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												07076			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY			Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Rural Bethesda			26 1/2 hr.			b. STATE			Maryland			
c. LENGTH OF STAY IN 1b									b. COUNTY			Montgomery			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			Potomac River at Little Falls Md.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Bethesda			
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	d. STREET ADDRESS			5028 Westpath Terrace		
5. SEX			6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	FUNDER 1 YEAR	FUNDER 24 HRS.		e. IS RESIDENCE ON A FARM?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
M.			W.	WIOOWEO <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 27, 1952	13 yrs.	7	18	Hours						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?						
Student			-----			Washington, D. C.			U. S.						
13. FATHER'S NAME			Wayne P. Brobeck			14. MOTHER'S MAIDEN NAME			Elizabeth Rohrer						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			No			16. SOCIAL SECURITY NO.			17. INFORMANT			Address			
						Unknown			Father Wayne P. Brobeck			Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b)	Drowning -									5 min.		
			DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			Swimming in River - caught in undertow of dam.						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour p.m. 5/15 1966			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River			20f. (City or town) Bethesda Mont. Md.			(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City, town or county)			(State)			
Burial-transit 5-18-66			Town Cemetery						Strasburg, Penna.						
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
ROBERT A. PUMPHREY, Bethesda, Maryland						MAY 19 1966			Charles Judge						



FOR STATE
HEALTH DEPT.

07087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07077

If any delay is necessary, please exercise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>20 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <i>8023 Eastern Ave.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. STREET ADDRESS <i>8023 Eastern Ave.</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>Annie Marie Bronson</i>		4 DATE OF DEATH Month Day Year <i>5 - 2 1966</i>	
5 SEX <i>Female</i>		6 COLOR OR RACE <i>White</i>	
7 MARRIED WIDOWED <i>Never married</i>		8 NEVER MARRIED DIVORCED <i>Divorced</i>	
9a. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stenographer</i>		9b. DATE OF BIRTH <i>April 19, 1915</i>	
10a. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>		9c. AGE (in years last birthday) yrs <i>51</i>	
10b. FATHER'S NAME <i>Burton L. Bronson</i>		11. MOTHER'S MAIDEN NAME <i>Louise E. Raymond</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) <i>No</i>	
14. SOCIAL SECURITY NO <i>Yes</i>		15. INFORMANT <i>Records Wilcox & McCallen Funeral Home Watertown, New York</i>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute asphyxiation due to aspiration</i>		17. INTERVAL BETWEEN ONSET AND DEATH <i>10</i>	
DUE TO <i>of gastric contents.</i>			
DUE TO <i>of gastric contents.</i>			
DUE TO <i>(c)</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. TIME OF INJURY Month, Day, Year Hour:Min p.m. <i>4/30 1966</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Deceased vomited and aspirated gastric contents.</i>	
20c. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <i>Home</i>		20d. (City or town) (County) (State) <i>Silver Spring Montg Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belen R. Reap M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Belen R. Reap M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <i>May 2, 1966</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 7, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Glenwood Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Watertown, New York</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Glen Curtis 8434 Georgia Avenue Warren E. Pumphrey, Inc. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>MAY 5 1966</i>	
		25b. REG STRAR'S SIGNATURE <i>Charles Judge</i>	





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

00 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
<u>Montgomery</u>		a. STATE <u>MARYLAND</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>14 days 10 1/2 hrs</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				
3. NAME OF DECEASED (Type or print) <u>Ella</u>		f. STREET ADDRESS <u>8127 14th Avenue</u>				
3. NAME OF DECEASED (Type or print) <u>Ella</u>		4. DATE OF DEATH <u>May 15 1966</u>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		8. DATE OF BIRTH <u>July 18, 1893</u>				
10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>72 yrs.</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
13. FATHER'S NAME <u>Bud Hodge</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <u>Nephrosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u> <u>years</u>				
DUE TO <u>Tremor</u> (b) DUE TO <u>Nephrosis</u> (c) Generalized arterioclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Acute diverticulitis of colon with hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>
21. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>4/30</u> , 19 <u>66</u> , to <u>5/15</u> , 19 <u>66</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>3/15</u> 19 <u>66</u> , and that death occurred at <u>2nd 4 M</u> , from the causes and on the date stated above.		22b. DATE SIGNED <u>5/15/66</u>				
22a. SIGNATURE <u>Jules J. Cahan</u>		22b. ADDRESS <u>WASH. SAN. & HOSP. TAKOMA PK. MD</u>				
22c. PHYSICIAN'S NAME (Type) <u>JULIUS J. CAHAN, M.D.</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Synday</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/18/66</u>		23d. LOCATION (City, town or county) <u>Beckley West Va.</u>		
24. FUNERAL DIRECTOR <u>Keyser-Bryant</u>		ADDRESS <u>Beckley West Va.</u>		25a. REC'D BY REGISTRAR <u>MAY 17 1966</u>		
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7089

CERTIFICATE OF DEATH

97079

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>District of Columbia</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SEASIDE</i>		b. COUNTY <i>District of Columbia</i>	
c. LENGTH OF STAY IN 1b <i>3 months</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>DISTRICT OF COLUMBIA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>C. Brooke Grove Foundation</i>		d. STREET ADDRESS <i>2800 Quebec St N.W.</i>	
e. FIRST NAME First: <i>Reuth</i> Middle: <i>EVANGELINE</i> Last: <i>BULL</i>		4. DATE OF DEATH Month: <i>May</i> Day: <i>28</i> Year: <i>1966</i>	
3. NAME OF DECEASED (Type or print)		5. SEX <i>F</i>	
6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	
8. DATE OF BIRTH <i>4-20-87</i>		9. AGE (in years) IF UNDER 1 YEAR Last birthday: <i>29</i> yrs. Months: <i>0</i> Days: <i>0</i> IF UNDER 24 HRS. Hours: <i>0</i> Min: <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Howard County-Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Nicholas Loop</i>		14. MOTHER'S MAIDEN NAME <i>Gisella Bradley Loop</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, date of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Glen C. Bull, Jr.</i>		Address <i>#2 Above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO <i>4721</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) <i>Arterio sclerotic cardiovascular disease</i> DUE TO (c) <i>10 yr</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>March</i> , 1966, to <i>May</i> , 1966, that (I) (we) last saw the deceased alive on <i>May 26</i> , 1966, and that death occurred at <i>11:15 A.M.</i> from the causes and on the date stated above			
22e. SIGNATURE <i>A.D. Bonyant</i>			
22e. PHYSICIAN'S NAME (Type) <i>A.D. BONYANT</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>Sixty Springs</i>	
23e. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>5/31/66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>JOSEPH GARDNER'S SONS, INC.</i>		23d. LOCATION (City, town or county) <i>KOKOMO, INDIANA</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gardner Son</i>		ADDRESS <i>WASH. D.C.</i>	
25a. REC'D BY REGISTRAR <i>JUN 3 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



18
FOR STATE
HEALTH DEPT.

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07090

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film 6216 7/16/66 mn

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

4733 Bradley Blvd., Apt. 1

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

5. SEX

Male

6. COLOR OR RACE

Cauc.

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 14, 1913

9. AGE (in years
at birthday)
53 yrs.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

U.S. GOV'T

11. BIRTHPLACE (State or foreign country)

Keyser W.Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James P. Burns

14. MOTHER'S MAIDEN NAME

Hennetta Keenan

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of discharge/service)

Yes WW II

16. SOCIAL SECURITY NO.

17. INFORMANT

James P. Burns, Cumb. Md.

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO
(c)

Acute Coronary Thrombosis

Coronary Artery Heart Disease.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

May 3, 1966

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

BELOEN R. REAP M.D. wheaton

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 5/6/66

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

S. Peter & Paul Roman Catholic

22d. LOCATION (City, town, or county) (State)

Cumberland Md

23. FUNERAL DIRECTOR

Lam Stein Inc. Cumb. Md.

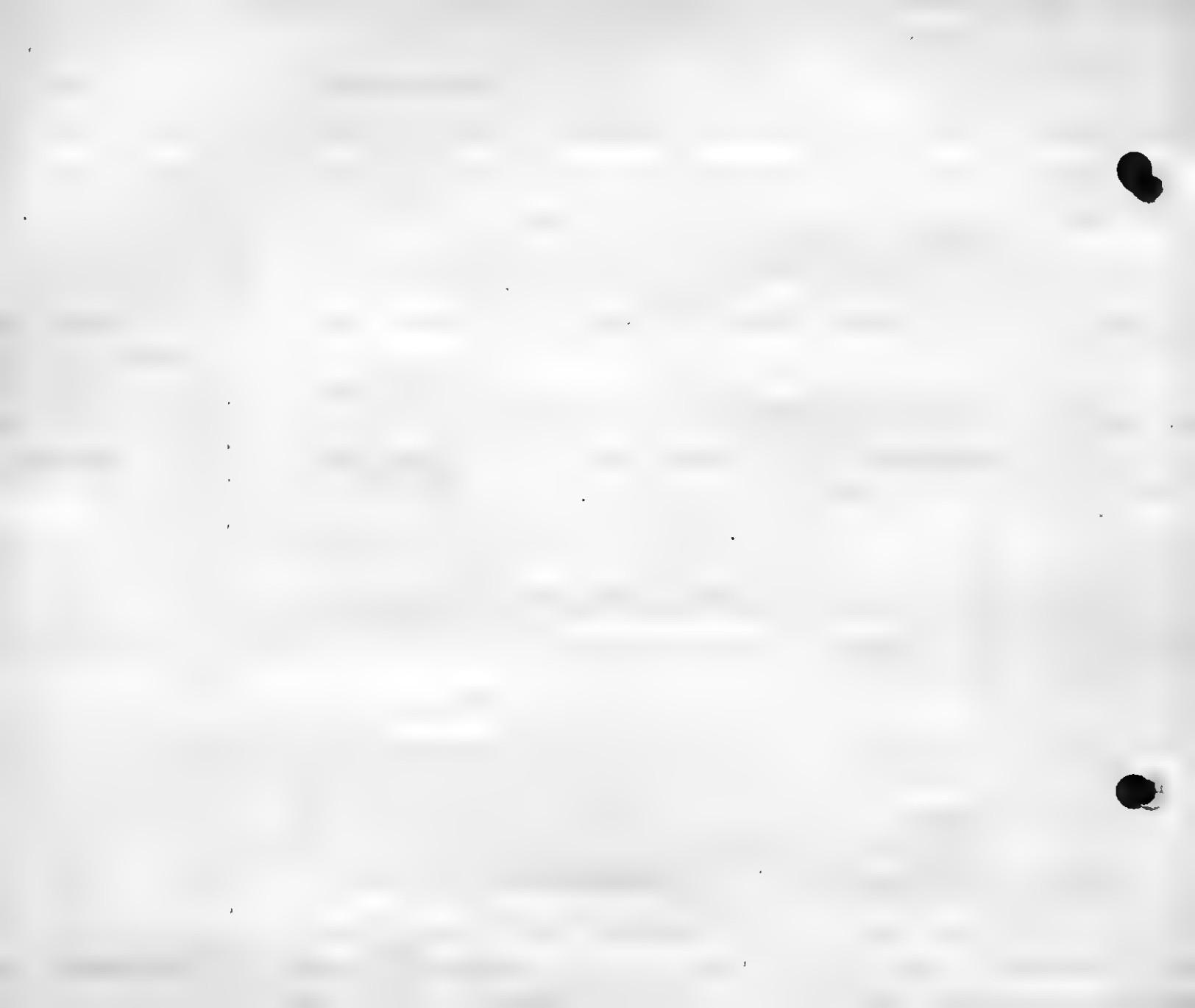
24a. REC'D BY REGISTRAR

MAY 9 1966

24b. REGISTRAR'S SIGNATURE

Charles Judge

07080



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

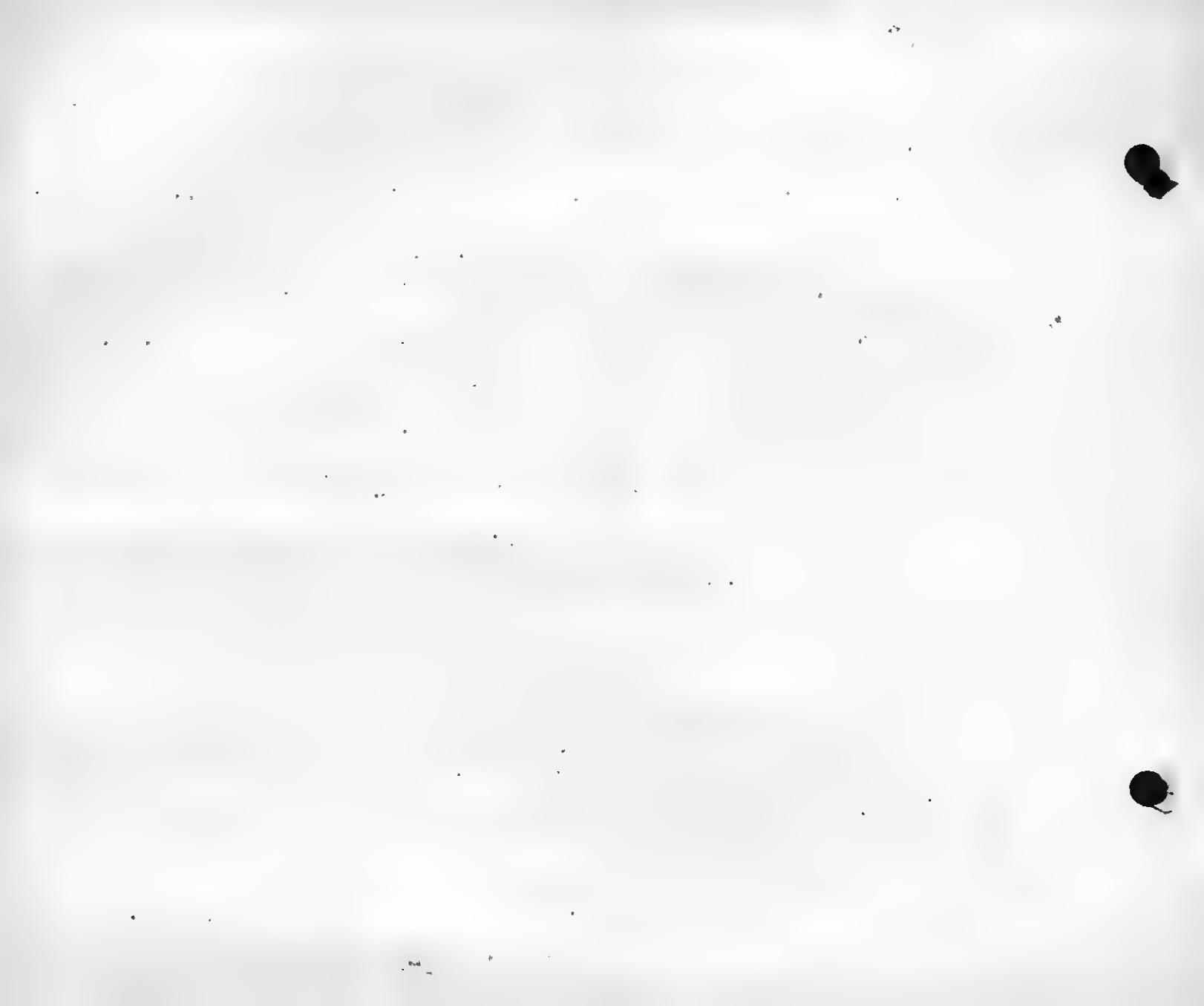
Reg. Dist. No.

C7091

C7081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.**TO FUNERAL DIRECTOR:** This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8903 Brookeville Road.,		d. STREET ADDRESS 8903 Brookeville Road.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>G. Carter</i>	Middle <i>Marta</i>	Last <i>Carter</i>	4. DATE OF DEATH <i>Sept. 10, 1966</i>	Month <i>Sept</i>	Day <i>10</i>	Year <i>1966</i>	
5. SEX female		6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1901	9. AGE (In years last birthday) 84	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Robert Brown		14. MOTHER'S MAIDEN NAME Charlotte Scott							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT William R. Carter: Item # 2		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Chronic Hypocardiac Disease</i> DUE TO <i>Chronic Hypocardiac Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypotension</i> DUE TO (c) <i>Hypotension</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>None</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Sandy Spring		(County) Md.	(State) Md.
21. I certify that I attended the deceased from <i>Sept. 7, 1966</i> to <i>Sept. 10, 1966</i> that I last saw the deceased alive on <i>Sept. 11, 1966</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John R. Rogers, M.D.</i> ADDRESS <i>1317 Glenmont Rd., Bethesda, Md.</i> DATE SIGNED <i>Sept. 11, 1966</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/66		22c. NAME OF CEMETERY OR CREMATORIUM Ash Memorial		22d. LOCATION (City, town, or county) Sandy Spring, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Sundeen</i>		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR MAY 25 1966		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C7092

CERTIFICATE OF DEATH

Reg. Dist. No.

C7082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>10 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9008 Fairview Rd.</i>		d. STREET ADDRESS <i>9008 Fairview Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mary</i>		First	Middle	Last	4. DATE OF DEATH Month <i>May</i> Day <i>29</i> Year <i>1966</i>		
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>Aug 15-1898</i>	9. AGE (In years lost birthday) <i>67</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS Hours <i>0</i> Min. <i>0</i>
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>	
13. FATHER'S NAME <i>Alfred H. Burdine</i>		14. MOTHER'S MAIDEN NAME <i>Mary Eliz. Lytle</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		Address <i>James Casbarian - 9008 Fairview Rd.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> 16. SOCIAL SECURITY NO. <i>INFORMANT</i> <i>James Casbarian - 9008 Fairview Rd.</i>							
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Carcinoma of Breast</i> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <i>Sept 65</i> <i>June 63</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AN AUTOPSY PERFORMED? None YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 1965</i> to <i>May 1966</i> that I last saw the deceased alive on <i>May 29 1966</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James W. Egan</i>		ADDRESS (Street, city or town, state) <i>5413 Cedar Lane-Bethesda, Md.</i> DATE SIGNED <i>5/29/66</i>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>6/1/66</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Company</i>		ADDRESS <i>2901 14th St. N.W. Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>JUN 2 1966</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

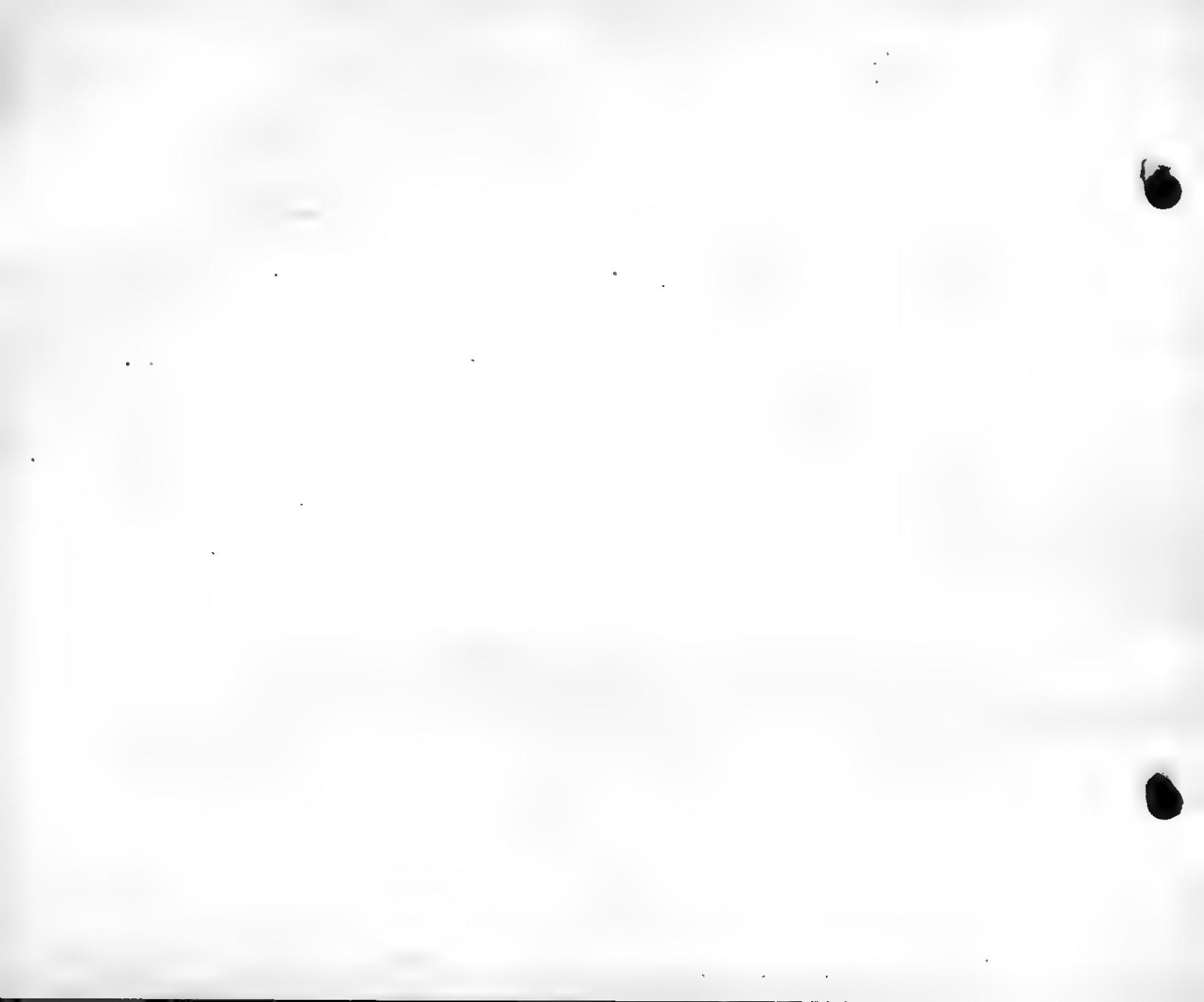
Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

67093

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67084

1 PLACE OF DEATH a COUNTY MONTGOMERY			2 USUAL RESIDENCE (Where deceased lived) <input type="checkbox"/> INSTITUTION <input type="checkbox"/> Residence before admission a STATE MARYLAND		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c LENGTH OF STAY IN lb DOA		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL			d STREET ADDRESS Whitmoor Terrace 252 Whitmoor Terrace		
			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)		First Katherlyn	Middle D.	Last Chapman	4. DATE OF DEATH May 26 1966
S SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 3/15/01	9. AGE (In years last birthday) 65 yrs
10 Do: USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Consultant		10b KIND OF BUSINESS OR INDUSTRY Government		11 BIRTHPLACE (State or foreign country) Pansy, Alabama	
13 FATHER'S NAME ABNER DAWSEY			14 MOTHER'S MAIDEN NAME EUGENIA WHIDDEN		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No None		16 SOCIAL SECURITY NO 266-38-3570		17 INFORMANT RALPH CHAPMAN-Husband Address 252 Whitmore Terrace Silver Spring, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) DUE TO (c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Belden R. Regan</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <i>BELDEN R. REGAN M.D.</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> CO-CHIEF MEDICAL EXAMINER <input type="checkbox"/> Address (Street, City, Town, or county) <i>Arlington, Virginia</i>					
23a. BURIAL CREMATION, BURIAL		23b. DATE THEREOF 28 May 1966	23c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cem.	23d. LOCATION (City or Town) Arlington, Virginia	(County) (State)
24. FUNERAL DIRECTOR <i>Frank J. Thomas</i> <i>Warren E. Pumphrey, Inc.</i>		ADDRESS 8434 Georgia Avenue Silver Spring, Maryland	25a. REC'D BY REGISTRAR MAY 31 1966	25b. REGISTRAR'S S.S. SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C7094

CERTIFICATE OF DEATH

C7085

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <i>Washington, D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>2 months</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital, give street address) <i>Fairland Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (AKA) <i>Maude Lee Clark Shreve</i>		DATE OF DEATH Month Day Year <i>May 14 1966</i>	
S. SEX <i>Female</i>	b. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>January 18 1879</i>
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		9. AGE (In years lost birthday) <i>87 yrs</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Grant's Store</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Jenny J. Finks</i>		14. MOTHER'S MAIDEN NAME <i>Sarah V. Groves</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>578-07-9520</i>	
17. INFORMANT <i>Mrs. Gertrude V. Clark (above address)</i>		Address <i>(Laughter) dress</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4500</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Renal Insufficiency</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Generalized arteriosclerotic Vascular Disease</i>	
(b) DUE TO <i>Generalized arteriosclerotic Vascular Disease</i>			
(c) DUE TO <i>Breath</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street office bldg. etc.) <i>31</i>
20f. (City or town) <i>5/14</i>		(County) (State) <i>1966</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>3/1</i> , 1966, to <i>5/14</i> , 1966, that (I) (we) last saw the deceased alive on <i>5/14</i> 1966, and that death occurred at <i>5/14</i> M, from causes and on the date stated above			
22a. SIGNATURE <i>Bernard A. Fitzgerald</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>		22d. ADDRESS <i>217 Union Blvd E, Sol. Sp. Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/17/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Glenwood Cemetery</i>
24. FUNERAL DIRECTOR <i>Nalloy's Funeral Home Inc.</i>		ADDRESS <i>Mt. Rainier Maryland</i>	25a. REC'D BY REGISTRAR <i>MAY 18 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



Items 18-21 Film G378 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil, on Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

C7095		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						C7086			
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)									
a. COUNTY <i>Montgomery</i>		a. STATE <i>MARYLAND</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San + Hospital</i>		d. STREET ADDRESS <i>10225 Riggs Rd</i>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>Clifford Joe Clayton</i>		First	Middle	Last	4. DATE OF DEATH Month <i>5</i>	Day <i>14</i>	Year <i>1966</i>				
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	DATE OF BIRTH <i>1-15-47</i>	9. AGE (In years last birthday) <i>19</i>	F UNDER 1 YEAR Months <i>0</i>	F UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of work no. of weeks even if retired) ACT. D.Y ENLISTED		10b. KIND OF BUSINESS OR INDUSTRY <i>US ARMY</i>			11. BIRTHPLACE (State or foreign country) <i>WASHINGTON, DC</i>			12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>			
13. FATHER'S NAME <i>Clifford Talmadge CLAYTON (LIVING)</i>		14. MOTHER'S MAIDEN NAME <i>Jane Rainey</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes Apr 20-66</i>		16. SOC. A. SECURITY NO <i>213-46-9411</i>			17. INFORMANT <i>Clifford Talmadge CLAYTON/FATHER/SEE ITEM #1</i>			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1/14</i>		cardiac Lacerations right Ventricle & Multiple						INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Traumatic Injuries.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) <i>Deceased drag racing, lost control of car and crashed through bridge rail</i>									
20c. TIME OF M.J.R.Y Month, Day, Year <i>2:10 AM 5/14 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) <i>Street</i>		20f. (City or town) <i>Adelphia P. G. md.</i>		(County) <i></i>		(State) <i></i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden R. Keap M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <i>BELDEN R. KEAP M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
		Address (Street, city, town, or county) <i>Arlington National Cemetery</i>									
23a. BURIAL, CREMATION OR MOVE (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>5/17/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>ARLINGTON NATIONAL CEM.</i>		23d. LOCATION (City or Town) <i>ARLINGTON VA.</i>		(County) <i></i>		(State) <i></i>	
24. FUNERAL DIRECTOR <i>W.W. CHAMBERS INC. SILVER SPRING MD</i>		ADDRESS <i>SILVER SPRING MD</i>		25a. RECEIVED BY REGISTRAR DATE <i>MAY 18 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial/cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

67096

CERTIFICATE OF DEATH

07087

1. PLACE OF DEATH
a. COUNTY

Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 16

MARYLAND

35 min.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington San. + Hospital

First
3. NAME OF
DECEASED
(Type or print)

Middle

4. SEX

6. COLOR OR RACE

Female

white

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Maryland

13. FATHER'S NAME

Bill Colie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

None

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Record-Washington San. + Hosp., Takoma Park, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congenital Heart Defect & cleft palate

1545

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Pneumonitis

INTERVAL BETWEEN ONSET AND DEATH

24 hrs.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20d. INJURY OCCURRED While Not While at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from *May 14, 1966*, to *May 14, 1966*, that (I) (we) last saw the deceased alive on *May 14, 1966*, and that death occurred at *50* M, from the causes and on the date stated above.

22a. SIGNATURE

Allen S. Gardner, M.D.

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

May 15, 1966

22c. PHYSICIAN'S NAME (Type)

Allen S. Gardner, M.D.

22d. ADDRESS

1807 Elton Lane, Silver Spring, Md.

22b. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE THEREOF
17 May 1966

23c. NAME OF CEMETERY OR CREMATORIAL
Parklawn Cemetery

23d. LOCATION (City, town or county)

Rockville, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Warren E. Murphy, Inc.

ADDRESS
*8434 Georgia Avenue
Silver Spring, Md.*

25a. REC'D BY REGISTRAR
MAY 20 1966

25b. REGISTRAR'S SIGNATURE
Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

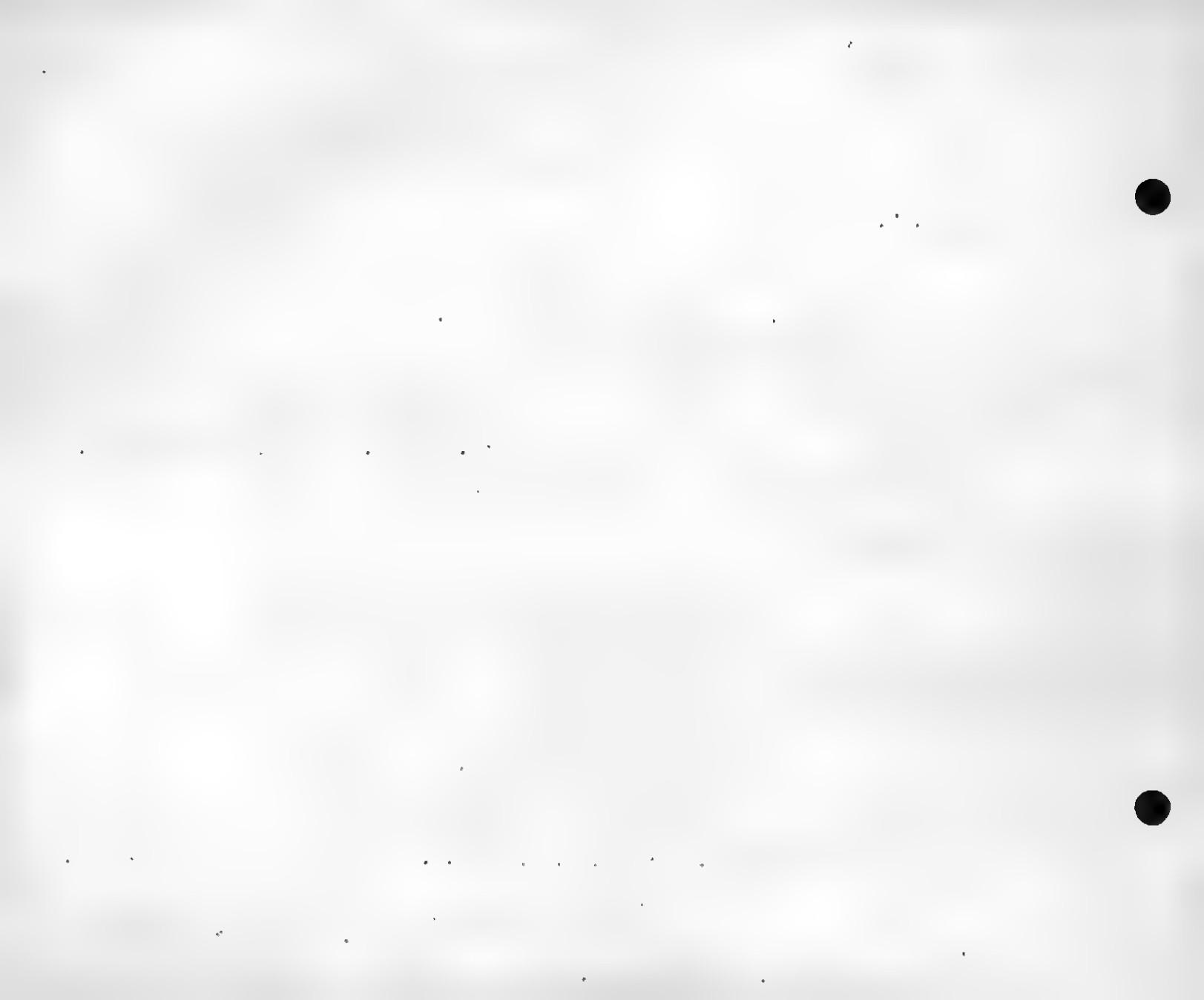
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

67088



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

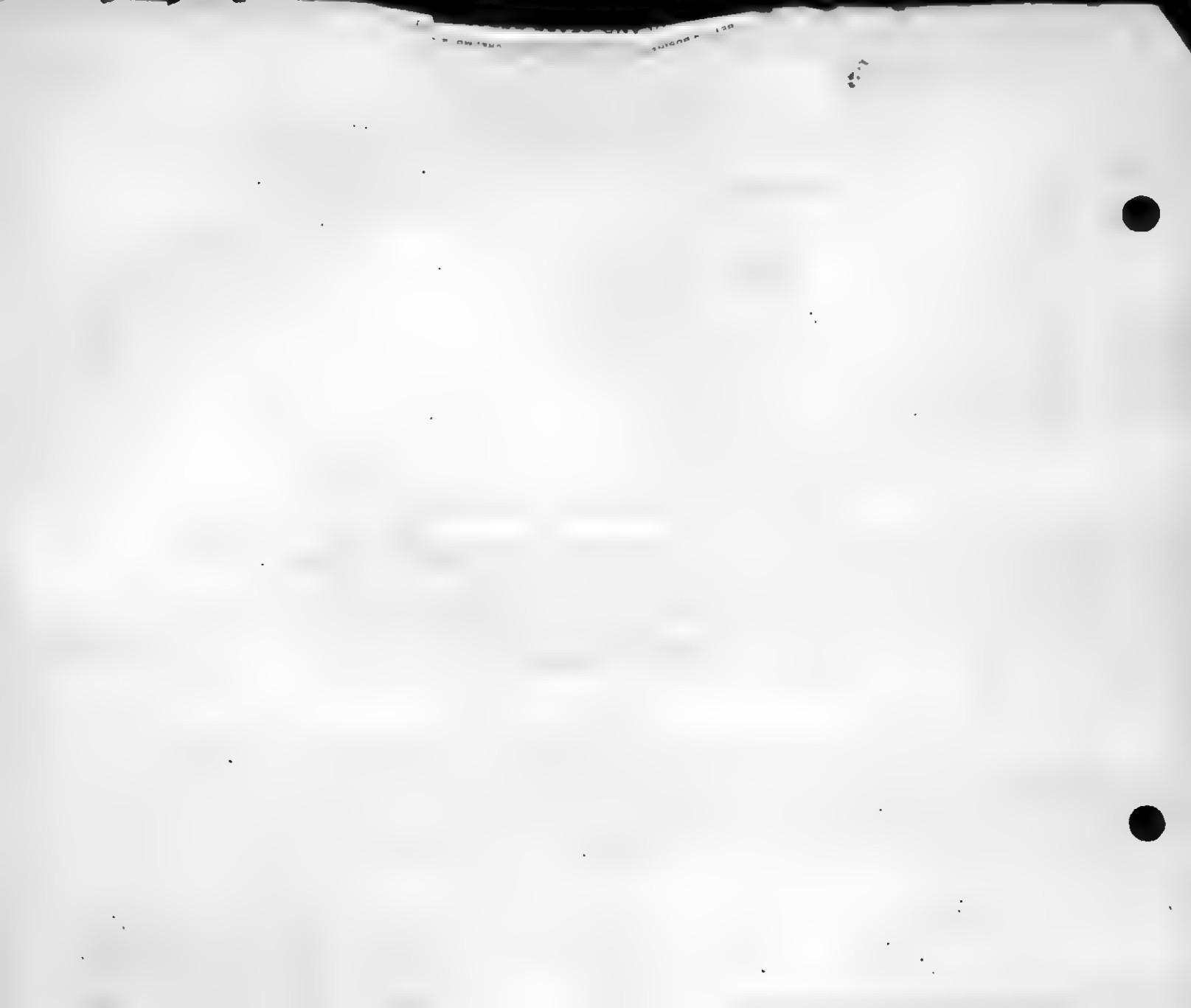
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

97093

CERTIFICATE OF DEATH

57089

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
<i>Hontochery</i> MARYLAND		a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Bobby</i>	Middle <i>Cirib L.</i>	Last <i>Cobson</i>		
4. DATE OF DEATH	Month <i>5</i>	Day <i>2</i>	Year <i>1966</i>		
5. SEX	6. COLOR OR RACE <i>Male</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/28/66</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Honor</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Montgomery, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>KENNETH Cobson</i>	14. MOTHER'S MAIDEN NAME <i>Barbara Combs</i>	Address <i>1 Farleyen</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>	16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT <i>J Farleyen</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral atelectasis</i> DUE TO (b) <i>Post-operative repair of meningomyelocele</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
INTERVAL BETWEEN ONSET AND DEATH <i>19/11</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>While at work</i>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>110 Spring St Silver Spring, Md.</i>	20f. (City or town) <i>110 Spring St Silver Spring, Md.</i>	(County) <i>Montgomery Co.</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>4/28/66</i> to <i>5/2/66</i> , that (I) (we) last saw the deceased alive on <i>5/2/66</i> , and that death occurred at <i>110 Spring St Silver Spring, Md.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>5/2/66</i>			
22a. SIGNATURE <i>Marvin Jones</i>		22c. PHYSICIAN'S NAME (Type) <i>MARVIN JONES</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <i>110 Spring St Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Funeral</i>	23b. DATE THEREOF <i>5-4-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Calvary Cemetery</i>	23d. LOCATION (City, town or county) <i>Baltimore, Md.</i>		
24. FUNERAL DIRECTOR <i>P.M. West, Esq. et al., Esq. et al.</i>	ADDRESS <i>110 Spring St Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE <i>MAY 4 1966</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

C7099

CERTIFICATE OF DEATH

07090

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. COUNTY Northumberland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Paxinos	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS Box 84	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First John Middle Conbere Last		4. DATE OF DEATH Month 5 Day 5 Year 1966	
5. SEX M. COLOR OR RACE gr		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Movie Projectionist		8. DATE OF BIRTH 10-28-01 9. AGE (in years last birthday) 64 yrs. IF UNDER 1 YEAR Months 6 Days 7 Hours 0 Min	
10b. KIND OF BUSINESS OR INDUSTRY Movies		11. BIRTHPLACE (County & State or foreign country) Shamokin Penn	
13. FATHER'S NAME Phill		14. MOTHER'S MAIDEN NAME Gatherine Forbes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Address Wye Dorothy Conbere (Same as above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic aortic valvulitis, chronic DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Shamokin (County) Pennsylvania (State)	
21. I certify that (I) (this hospital) attended the deceased from April 19 1966 to May 19 1966 , and that death occurred at 6 AM , from causes and on the date stated above			
22a. SIGNATURE John J. Daum		22b. DATE SIGNED 5 May 66	
22c. PHYSICIAN'S NAME (Type) JEBE J. DAUM		22d. ADDRESS 1977 BATTERY LINE BETHESDA MD	
23a. BURIAL, CREMATION, REMOVALS, ETC. Burial		23b. DATE THEREOF 5/6/1966	
23c. NAME OF CEMETERY OR CREMATORIAL St. Edwards Cemetery		23d. LOCATION (City or Town) Shamokin (County) Pennsylvania (State)	
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR May 9 1966		25b. REGISTRAR'S SIGNATURE John J. Daum	

1

FOR STATE
HEALTH DEPT.

C7100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7091

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Silver Spring MD		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. STREET ADDRESS 12217 Centerhill St.	
3 NAME OF DECEASED (Type or print) Donald Lynn Connally		4. DATE OF DEATH Month May Day 12 Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S. SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Sandy Spring, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donald L. Connally		14. MOTHER'S MAIDEN NAME Vera Estelle Swartzbach	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service		16. SOCIAL SECURITY NO None	
17. INFORMANT Stepfather, Roland Repass		Address 12217 Centerhill Sil. Spr., Md.	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 8154 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) transection of aorta with exsanguination. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20c. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18) Deceased, riding bicycle, struck by auto.	
20c. TIME OF INJURY Month, Day, Year Hours: 5:40 p.m. 5/12 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) Street
20f. (City or town) Silver Spring Montg. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) <i>Wheaton</i>	
22. DATE SIGNED <i>May 12, 1966</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/16/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Darnestown</i>
23d. LOCATION (City or Town) <i>Darnestown</i>		(County) (State) <i>Maryland</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>		25a. REGISTRATION NUMBER <i>1991 Rockville, Rockville, Maryland</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>MAY 18 1966</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 File 3077 6/7/66 m

CERTIFICATE OF DEATH

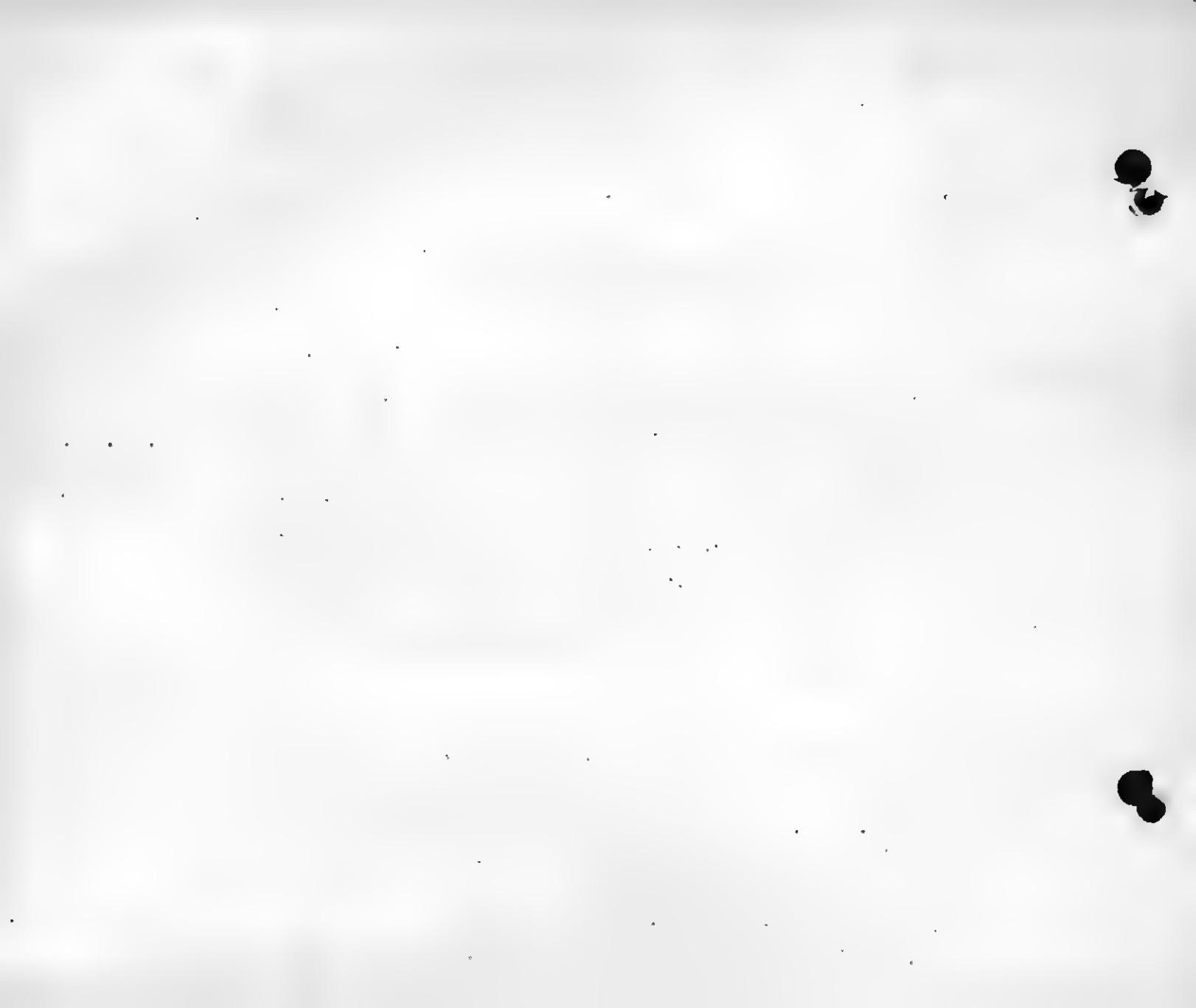
Reg. Dist. No. 67092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

C7101

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 10225 Kensington Parkway Apt. 715		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10225 Kensington Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Marie	Middle Louise	Last Conner	4. DATE OF DEATH	Month May	Day 3	Year 1966
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR			IF UNDER 24 HRS
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7/17/83 1882	82 yrs.	Months	Days	Hours	Min
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond, Va.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME James Stephenson		14. MOTHER'S MAIDEN NAME Ella D. Deupree						
IS WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		INFORMANT		Address		
		577-03-7281 Kenneth Conner-2705 Byron St. S.Sp. Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 15 years								
DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Carcinoma of breast with metastases 3 years								
DUE TO								
(c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from 1/1, 1950, to 5/3, 1966, that I last saw the deceased alive on 5/3, 1966, and that death occurred at 8:15 M, from the causes and on the date stated above.								
ACTUAL SIGNATURE John E. Everett M.D. 9400 Conn. Ave ADDRESS (Street, city or town, state) DATE SIGNED 5/3/66								
PHYSICIAN'S NAME (Type) JOHN E. EVERETT		Kensington, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5/6/66		22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) Prince Georges County, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company Washington, D.C. ADDRESS MAY 5 1966 REGISTRAR'S SIGNATURE Charles Judge								



FOR STATE
HEALTH DEPT.

C7102

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

37093

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If 24 hour delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. CO. IN KY <i>Montgomery</i>		MARYLAND		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) b. STATE <i>Maryland</i>		c. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If auto de corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If auto de corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		d. STREET ADDRESS <i>610 Bonifant St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <i>610 Bonifant street</i>				d. DATE OF DEATH Month Day Year <i>5 - 2 1966</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MILTON Stanley COOLEY</i>		First	Middle	Last	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Year Month Day <i>1902 Jan. 18, 1888</i>	9. AGE (In years last birthday) <i>84 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days Hours Min <i>0 0 0</i>
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baileys Liquors</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard Cooley</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Mast</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO <i>577-14-9310</i>		17. INFORMANT <i>Willie H. Cooley, Street., Silver Spring, Md.</i>		Address <i>610 Bonifant</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary insufficiency</i>				INTERVAL BETWEEN ONSET AND DEATH	
Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) <i>Arteriosclerotic heart disease</i>					
DUE TO		DUE TO					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Washington, D. C.</i>	(County) (State)
ACTUAL SIGNATURE <i>Belden R. Reap M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <i>May 3, 1966</i>	
EXAMINER'S NAME (Type) <i>Belden R. Reap M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 5, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Glenwood</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR <i>Varner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Ga Ave., S.E. Md.</i>		25a. REC'D BY REGISTRAR <i>MAY 9 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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07103

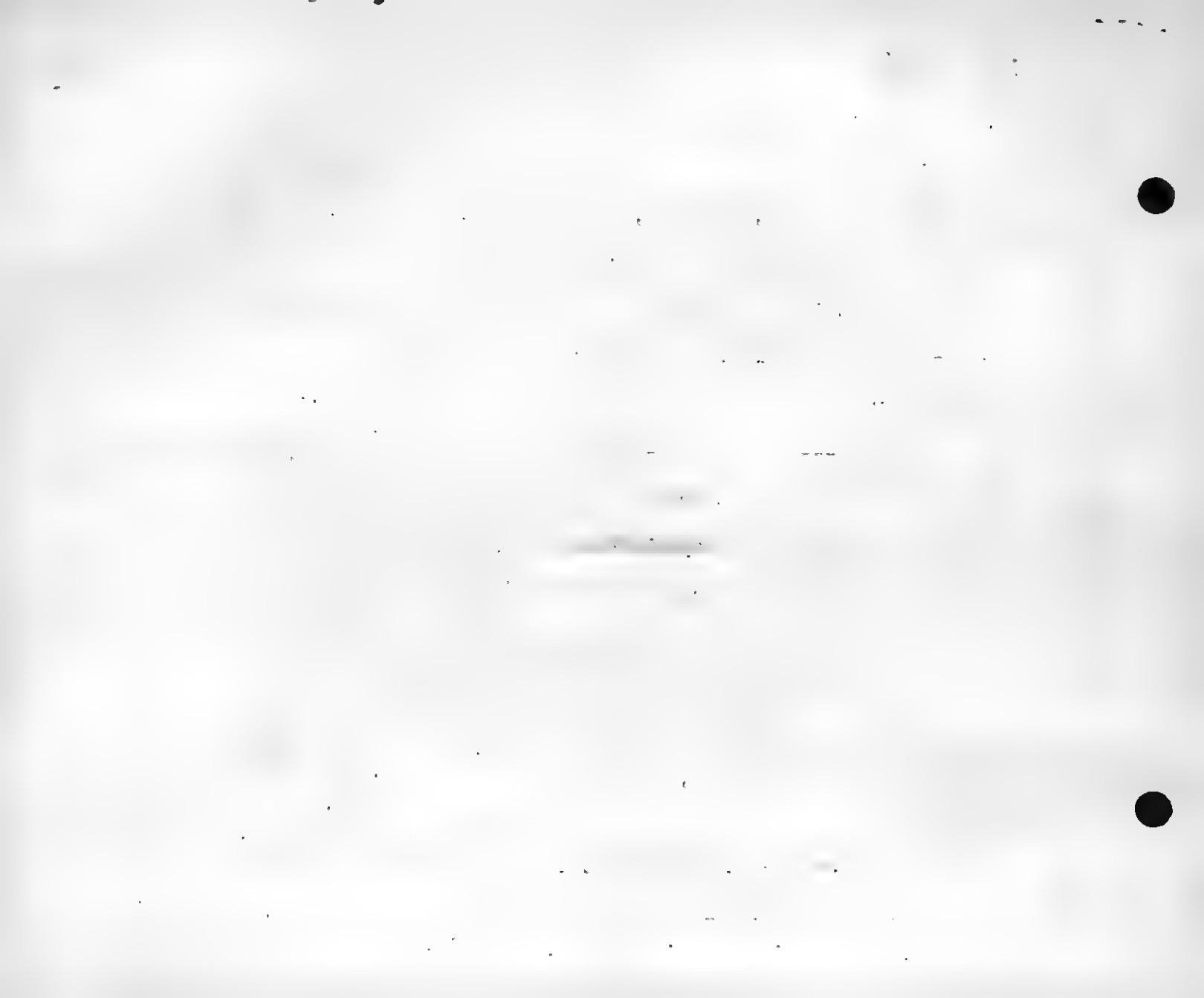
CERTIFICATE OF DEATH

07094

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville	
3. NAME OF DECEASED (Type or print) Harold Dean Crum		d. STREET ADDRESS 225 North Broadway Street	
4. DATE OF DEATH Month Day Year May 12, 1966		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 31 December 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto-body repair worker		10b. KIND OF BUSINESS OR INDUSTRY Automotive	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harley Crum		14. MOTHER'S MAIDEN NAME Hattie Beabout	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 286-03-8048	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia			
416X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Hepatic insufficiency		2 months	
DUE TO (c) Rheumatic heart disease		40 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. April 27, 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Barnesville
20f. (City or town) Barnesville		(County) (State)	
21. I certify that William W. Parmley (this hospital) attended the deceased from April 27, 1966 , to May 12, 1966 , that we last saw the deceased alive on May 12, 1966 , and that death occurred at 12:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE William W. Parmley		22b. DATE SIGNED May 12, 1966	
22c. PHYSICIAN'S NAME (Type) William W. Parmley, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 5-13-66		23b. DATE THEREOF Crestview Cemetery	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bethesda, Maryland		23d. LOCATION (City, town or county) (State) Barnesville, Ohio	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE MAY 17 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

57104

CERTIFICATE OF DEATH

32095

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Pennsylvania</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			c. LENGTH OF STAY IN b. <i>52 days</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkins Park</i>		
f. STREET ADDRESS <i>305 Waring Road</i>			g. DATE OF DEATH Month Day Year <i>May 14 1966</i>		
3. NAME OF DECEASED (Type or print) <i>Edwin</i>			First <i>Edwin</i>	Middle <i>Cubler</i>	Last <i>Cubler</i>
4. SEX <i>Male</i>	5. COLOR OR RACE <i>White</i>	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	7. NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/06/02</i>	9. AGE (In years to birthday) <i>63 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Project Manager</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Balto. Construct. Co.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Phila Pa</i>	
13. FATHER'S NAME <i>Jacob Cubler</i>		14. MOTHER'S MAIDEN NAME <i>Sarah ?</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT <i>Hospital Records</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infarct, myocardial, massive</i> DUE TO <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arteriosclerosis, coronary, severe</i> (c)					
INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Confluent lobular pneumonia, total.</i>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>May 19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5-22-66</i> to <i>5-13-66</i> , that (I) (we) last saw the deceased alive on <i>5-13-66</i> , and that death occurred at <i>2 PM</i> , from causes and on the date stated above.					
22a. SIGNATURE <i>Robert R. Montgomery</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>5-14-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT R. MONTGOMERY</i>		22d. ADDRESS <i>5411 CEDAR LANE BETHESDA MD</i>			
23a. BURIAL, CREMATION, REMOVAL SPECIFY <i>Burial-transit 5-15-66</i>		23b. DATE THEREOF <i>5-15-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>West Laurel Hill Cemetery, Penna</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>		ADDRESS <i>Bethesda, Maryland</i>		25a. REC'D. BY REGISTRAR DATE <i>MAY 17 1966</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

67105

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

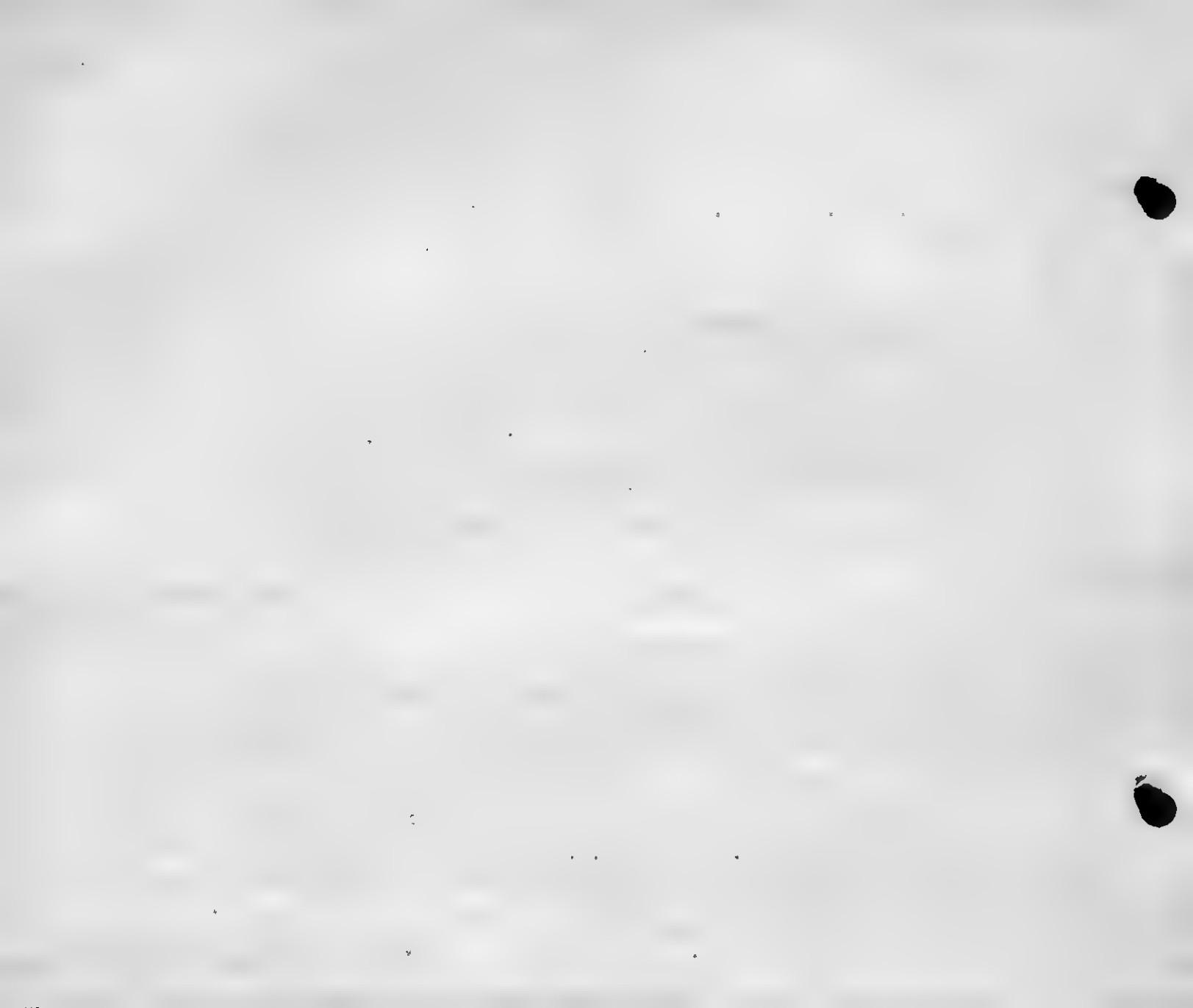
1. PLACE OF DEATH a. COUNTY MONTGOMERY			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			b. COUNTY MONT.		
c. LENGTH OF STAY IN lb 20 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RESMAR 5721 GROSVENOR LN. NURSING HOME			d. STREET ADDRESS 10021 DICKENS AVE		
3. NAME OF DECEASED (Type or print) PAUL J. CURRAN			4. DATE OF DEATH Month MAY Day 31 Year 1966		
S SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10-19-94	9. AGE (in years last birthday) 71
10a. US AL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER (RETIRED)			10b. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME HUGH CURRAN			14. MOTHER'S MAIDEN NAME ANNA McMASTER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No			16. SOCIAL SECURITY NO 276-10-7694		
17. INFORMANT Mrs. Rebecca B. Curran - Same as #2			Address		
18. CAUSE OF DEATH (Enter only one cause per line for Part I, (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Cerebral arteriosclerosis stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) May 31	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 1, 1966 to May 31, 1966 , that (I) (we) last saw the deceased alive on 5-24-1966 , and that death occurred at MD , from causes and on the date stated above.					
22a. SIGNATURE George A. Gray-Jr.			22b. DATE SIGNED 5/31/66		
22c. PHYSICIAN'S NAME (Type) George A. Gray-Jr.		22d. ADDRESS 4140 Chevy Chase Drive			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-3-66	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery	23d. LOCATED ON (City or Town) Suntland	(County) Maryland	(State)
24. FUNERAL DIRECTOR Francis J. Collins		ADDRESS 3821-14th St. NW	25a. REC'D. BY REGISTRAR JUN 2 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	



NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		b. COUNTY Pr. Geo.									
c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San. & Hosp.		d. STREET ADDRESS Adelphi									
3. NAME OF DECEASED (Type or print) Margaret F. Porter		4. DATE OF DEATH Year 2410 - Kirston St.									
5. SEX Female		6. COLOR OR RACE White									
7. MARRIED WIDOWED		8. NEVER MARRIED DIVORCED									
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days									
11. BIRTHPLACE (County & State, or foreign country) Ireland		12. IF UNDER 24 HRS Hours Min.									
13. FATHER'S NAME Robert Porter		14. MOTHER'S MAIDEN NAME Margaret Curran									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Joseph N. Curtin (above address) (Daughter)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure		Address INTERVAL BETWEEN ONSET AND DEATH 3 months									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4221 DUE TO Degenerative Cardio-vascular disease		5 years									
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work Not While at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from July 1948 , to May 14, 1966 , that (I) (we) last saw the deceased alive on May 13, 1966 , and that death occurred at 7 AM , from the causes and on the date stated above.											
22a. SIGNATURE Herbert G. Brandes		M.D.		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Herbert G. Brandes, M.D.		22d. ADDRESS 3400 University Blvd East Adelphi, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/66		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION (City, town or county) Wash., D.C.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR MAY 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 (4) 2DM 5-63											



1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

67098

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY Montgomery MARYLAND		a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Althea Woodland Nursing Home, 1000 Daleview Dr.		d. STREET ADDRESS 8500 - Dixon Avenue	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First: Katharine Middle: Marie		Last	4. DATE OF DEATH
		Cutler	5 30 1966
5. SEX Female		6. COLOR OR RACE white	
		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
		11. BIRTHPLACE (County & State, or foreign country) Rochester, New York	
13. FATHER'S NAME Henry Zahn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
		17. INFORMANT Mrs Gertrude Minor - #5 Silver Spring Rd., Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 251X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		Cerelene Lemarrage due to (b) Hypertension due to (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebrovascular disease		female yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Month Day Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 1957 , 19, to May 20, 1966	
21. I certify that (I) (this hospital) attended the deceased from May 19, 1966 , to May 20, 1966 , that (I) (we) last saw the deceased alive on May 19, 1966 , and that death occurred at 7:30 AM , from the causes and on the date stated above.		22b. DATE SIGNED May 20, 1966	
22a. SIGNATURE Raymond O. West		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Raymond O. West		22d. ADDRESS 831 University Blvd. E. Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) May 23, 1966		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Parklawn Cemetery	
24. FUNERAL DIRECTOR Warren E. Pumphrey, Inc. Silver Spring, Md.		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
		25a. REC'D BY REGISTRAR MAY 24 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

M

C7108

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7099

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. If City delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH Montgomery County		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland a. STATE Montgomery b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 1 year	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) 2807 Univ. Blvd. West		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) James Reddick Daniels		First James	Middle Reddick
3 NAME OF DECEASED (Type or print) James Reddick Daniels		Last Daniels	4 DATE OF DEATH Month 5 - 10
3 NAME OF DECEASED (Type or print) James Reddick Daniels		Day 19	Year 66
S SEX Male	6 CO. OR RACE White	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	8 NEVER MARRIED DIVORCED <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) Ret. Army Officer		10b KIND OF BUSINESS OR INDUSTRY ARMY	
11. BIRTHPLACE (State or foreign country) North Carolina		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME James A. Daniels		14 MOTHER'S MAIDEN NAME Hattie Hardison	
15 HAS DECEASED EVER BEEN IN U. S. ARMED FORCES? (If yes give rank or dates of service) Yes WWII 210-20-6189		16 SOC AL SECUR TY NO Jeanette M. Daniels (wife)	
17 INFORMANT Jeanette M. Daniels (wife)		Address SAME	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last with recent Infarction;		INTERVAL BETWEEN ONSET AND DEATH Acute Coronary Thrombosis	
DUE TO (b) DUE TO (c) Coronary Artery Heart Disease			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Arlington
20f (City or town) Arlington		(County) Virginia	
		(State) Virginia	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town or County) Attestation	
22. DATE SIGNED May 11, 1966			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 13 May, 1966	23c NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.
23d LOCATION (City or Town) Arlington		(County) Virginia	
		(State) Virginia	
24 FUNERAL DIRECTOR E. Warner & Sons, Inc.		25a ADDRESS 8434 Georgia Avenue Silver Spring, Md.	25b. REGISTRAR'S SIGNATURE Charles Judge
		25c REC'D BY REG STRR MAY 16 1966	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

C7103		07100	
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Silver Spring 3½ days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS Holy Cross Hospital 4304 Randolph Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Glenn		B	Darnell
4. DATE OF DEATH		Month	Day Year
May 19 1966		May	19 1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
M		W	May 18, 1906 60 yrs.
8. DATE OF BIRTH		9. AGE (In years) IF UNDER 1 YEAR last birthday) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)
Custodian at School		Jr. High-Sligo	Virginia
12. CITIZEN OF WHAT COUNTRY		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Charles W. Darnell		Sophie McVey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		244-09-2670	Wife Nannie V. Darnell
Address		Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Glenn negative Septicemia due to</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Prostatisurgery</i> DUE TO (c) <i>Prostatis Hyperplasia</i>			
INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 15 May 1966 to 19 May 1966, that (I) (we) last saw the deceased alive on 19 May 1966, and that death occurred at 3:35 AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Joseph Bloom</i>		22b. DATE SIGNED 5-19-66	
22c. PHYSICIAN'S NAME (Type) JOSEPH BLOOM		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 1015 Spring St., Silver Spring, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-66	23c. NAME OF CEMETERY OR CREMATORIUM Sherwood Cemetery
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	25a. REC'D BY REGISTRAR MAY 23 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C7110

CERTIFICATE OF DEATH

07102

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please leave carbon papers Pages 1 and 2, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Florida		b. COUNTY Santa Rosa	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milton		f. STREET ADDRESS 341 Merrill Drive		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michael Paul DAVIS		First	Middle	Last	4. DATE OF DEATH Month May 19 1966	Day	Year		
S. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7 Jan 1966	9. AGE (In years last birthday) yrs. 07 12	F UNDER 1 YEAR Months 07	IF UNDER 24 HRS Days 12		
10. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME William Joseph DAVIS		14. MOTHER'S MAIDEN NAME Margaret Hardman		15. Address 341 Merrill Drive					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NA		17. INFORMANT William J. DAVIS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 1545 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause first. Congestive Heart Failure & Turncus Arteriosis (b) DUE TO Turncus Arteriosis (c) DUE TO (Congenital Heart Disease)		INTERVAL BETWEEN ONSET AND DEATH 3 minutes	
19. MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. Naval Hospital, Bethesda, Md.	20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from 17 May 1966 , to 19 May 1966 , that (we) (we) last saw the deceased alive on 19 May 1966 , and that death occurred at 8:07 PM , from causes and on the date stated above.		22a. SIGNATURE E. G. Brown		22b. ATTENDING PHYS. E. G. Brown		<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	19 May 1966	
22c. PHYSICIAN'S NAME (Type) E. G. BROWN, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Transit 5-20-66	23c. NAME OF CEMETERY OR CREMATORIAL Linwood Cemetery	23d. LOCATION (City or Town) (County) Iowa	
24. FUNERAL DIRECTOR R.A. PUMPHREY Funeral Home		25a. ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		25b. REC'D BY REGISTRAR MAY 25 1966		25c. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by him. It should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 818 DAVIS AVENUE,		d. STREET ADDRESS 818 DAVIS AVENUE,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RUTH	First B.	Middle DAVIS	Last MAY 1 1966
4. DATE OF DEATH MAY 1 1966	Month	Day	Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/98.
9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/>	11. IF UNDER 24 HRS <input type="checkbox"/>	
Months	Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not red) STENOGRAPHER FED. GOVT. (RET.)		10b. KIND OF BUSINESS OR INDUSTRY CORNING, IOWA USA	
11. BIRTHPLACE (State or foreign country) CORNING, IOWA USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES MONROE BELKNAP		14. MOTHER'S MAIDEN NAME JENNIE BLACK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO. 216-44-4578	
17. INFORMANT MRS. KATHERINE B. NICHOLS - BUFFALO, N.Y.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1wk	
HEPATIC FAILURE			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		METASTATIC MALIGNANCY - Adenocarcinoma of Stomach 5 mo	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Adelphi, Md.	
(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from MARCH 3, 1966, to MAY 1, 1966 , that (I) (we) last saw the deceased alive on April 29, 1966 , and that death occurred at 9 P.M. from the causes and on the date stated above		22b. DATE SIGNED 5/1/66	
22c. SIGNATURE Maurice A. Capone		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) MAURICE A. CAPONE, M.D.		22d. ADDRESS 5600 Cronwell Drive, Wash 16, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 4, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL George Washington		23d. LOCATION (City, town, or county) Adelphi, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll NW		ADDRESS D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll NW		25a. REC'D BY REGISTRAR MAY 4 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

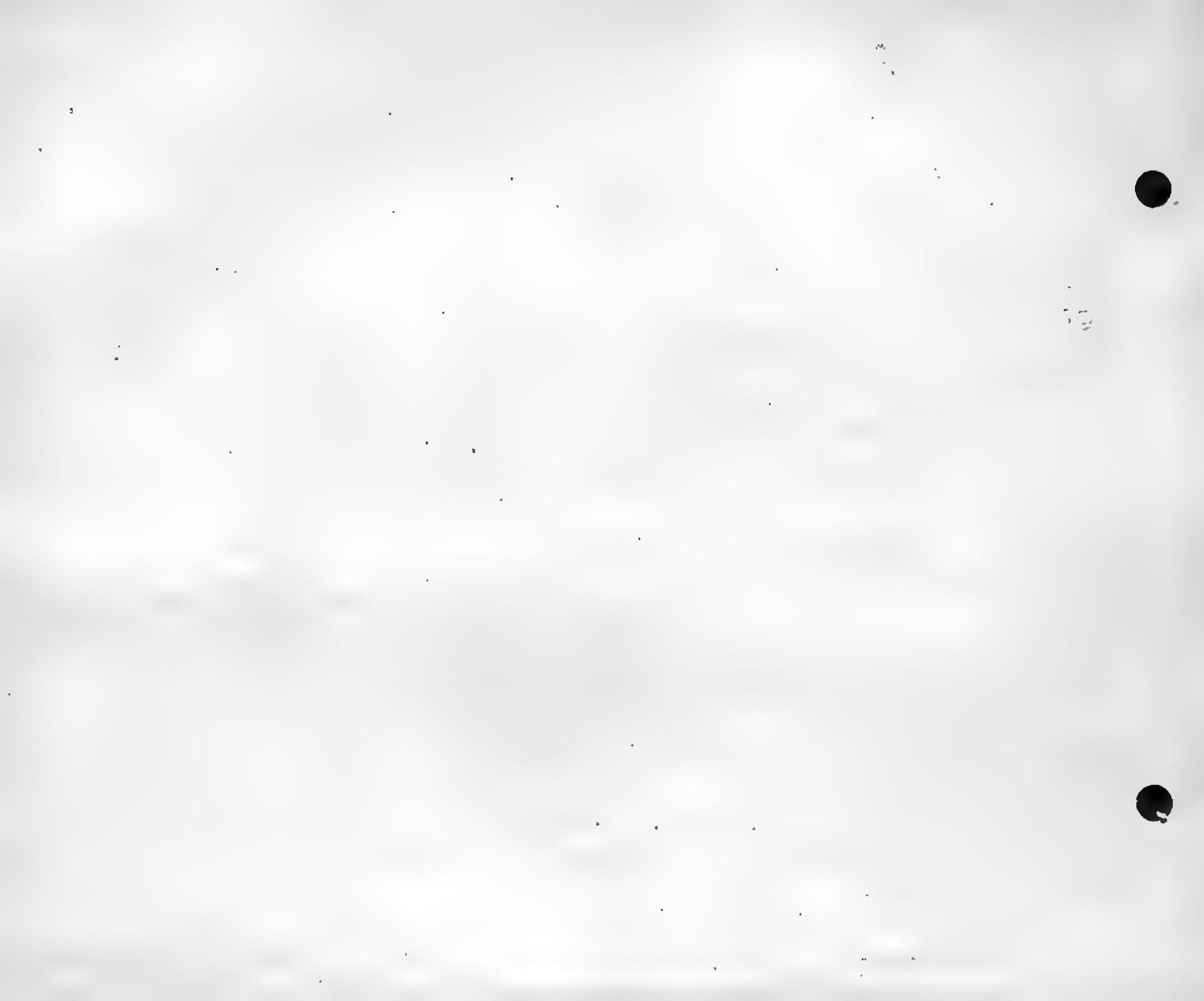
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE			
<i>Montgomery</i> <i>Takoma Park</i>		<i>Maryland</i> <i>Coxon Hill</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 25 days - 4 hrs - 40 min			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. STREET ADDRESS 6324 Furness Ave.			
3. NAME OF DECEASED (Type or print)	First <i>James</i>	Middle <i>Earl</i>	Last <i>Dean</i>		
4. DATE OF DEATH	Month <i>May</i>	Day <i>3</i>	Year <i>1966</i>		
5. SEX	6. COLOR OR RACE <i>Male</i> <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>9-12-00</i>		
9. AGE (in years last birthday)	10. FUNDER 1 YEAR IF UNDER 24 HRS Months <i>65</i> Yrs. <i> yrs.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>	10b. KIND OF BUSINESS OR INDUSTRY	14. MOTHER'S MAIDEN NAME <i>Yukonow</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO.	17. INFORMANT <i>Hospital Records</i>	Address <i>7600 Carroll Ave.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Emphysema - cor pulmonale</i> DUE TO (c) <i>Interstitial pulmonary fibrosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>4-7, 1966 to 5-3, 1966</i>	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Wash Sanitarium Takoma Park Md</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4-7, 1966</i> to <i>5-3, 1966</i> , that (I) (we) last saw the deceased alive on <i>5-3, 1966</i> , and that death occurred at <i>3:45 P.M.</i> from the causes and on the date stated above.	22a. SIGNATURE <i>Kenneth Cruz</i>	22b. DATE SIGN'D <i>5-3-1966</i>			
22c. PHYSICIAN'S NAME (Type) <i>Kenneth CRUZ</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. 22d. ADDRESS <i>Wash Sanitarium Takoma Park Md</i>	22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <i>5-3-1966</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 5/6/1966</i>	23b. DATE THEREOF <i>5/6/1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Cedars Hill</i>	23d. LOCATION (City, town or county) (State) <i>Sixland</i>		
24. FUNERAL DIRECTOR <i>Whitney 131-11th St. S.E. D.C.</i>	ADDRESS <i>Whitney 131-11th St. S.E. D.C.</i>	25a. REC'D BY REGISTRAR <i>MAY 6 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C7113

CERTIFICATE OF DEATH

07105

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in one event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>		c. LENGTH OF STAY IN lb <i>8 mos.</i>		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Mont</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Fairland Nursing Home, Fairland Rd.</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>			
3. NAME OF DECEASED (Type or print) <i>ANNA</i>		First	Middle	Lost	4. DATE OF DEATH <i>May 27 1966</i>	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>3/22/79</i>	9. AGE (In years last birthday) <i>87 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>- - -</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Till</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Jacob Denning</i>				14. MOTHER'S MAIDEN NAME <i>MARY PRICE</i>		Address <i>115 Colie Drive Wheaton MD</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>115 Colie Drive Wheaton MD</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>321X</i>		DUE TO (b) <i>Cerebral Insufficiency</i>						YEARS	
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumonia</i>									
20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4115 Colie Drive Wheaton MD</i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/1 1965</i> to <i>5/27 1966</i> , that (I) (we) last saw the deceased alive on <i>5/27 1966</i> , and that death occurred at <i>4115 Colie Drive Wheaton MD</i> , fram causes and on the date stated above.									
22a. SIGNATURE <i>Raymond T. Benack</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/27/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Raymond T. BENACK MD</i>		22d. ADDRESS <i>4115 Colie Drive Wheaton MD</i>							
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Cakes</i>		23b. DATE THEREOF <i>6/2/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cakes View Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Cakes, North Dakota</i>			
24. FUNERAL DIRECTOR <i>Cherry Chase Funeral Home</i>		ADDRESS <i>5101 Wisconsin Ave. N.W. Washington D.C.</i>		25a. REC'D BY REGISTRAR <i>3 JUN 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Charles</i>			
VR A15 (4) 20 M 1/66									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7114

CERTIFICATE OF DEATH

07106

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) b. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1B	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4627 Chestnut Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JAMES	Middle W.	Last DENT
4. DATE OF DEATH May 11, 1966	Month May	Day 11	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1900
9. AGE (in years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Days 5	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Part-Owner		10b. KIND OF BUSINESS OR INDUSTRY Glass Shop	
11. BIRTHPLACE (County & State, or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas B. Dent		14. MOTHER'S MAIDEN NAME Daisy P. Hayden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-09-4760	
17. INFORMANT Brother Thomas C. Dent		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG HEMORRAGE			
9081 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO TUBERCULOSIS (c) DUE TO LUNGS			
INTERVAL BETWEEN ONSET AND DEATH 7 HRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
10 YRS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
p.m. 19			
21. I certify that (I) (this hospital) attended the deceased from JAN 1954 to MAY 1966, that (I) (we) last saw the deceased alive on MAY 11 1966, and that death occurred at 15A M, from the causes and on the date stated above.			
22a. SIGNATURE Leo I. Donovan		22b. DATE SIGNED 5-11-66	
22c. PHYSICIAN'S NAME (Type) LEO I. DONOVAN		22d. ADDRESS 8218 Wisconsin Ave, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-13-66	
23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City, town or county) Cedar Hill Cemetery Suitland, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR MAY 17 1966	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

87115

CERTIFICATE OF DEATH

87107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 2 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
f. STREET ADDRESS 857 North Liberty Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry Thornton DIETRICH		First	Middle
4. SEX Male	5. COLOR OR RACE Cauc	6. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
7. DATE OF BIRTH 4 April 1904	8. AGE (In years lost birthday) 62 yrs	9. IF UNDER 1 YEAR Months 28	10. IF UNDER 24 HRS. Days 19
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Sandusky, Ohio	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George C. Dietrich	
14. MOTHER'S MAIDEN NAME Louisa Talbott		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES	
16. SOCIAL SECURITY NO. 300-34-8428		17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. 051X (b) DUE TO (c)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 26 May 1966 , to 28 May 1966 , that (I) (we) last saw the deceased alive on 28 May 1966 , and that death occurred at 2:40AM , from causes and on the date stated above.			
22a. SIGNATURE James S. Shumaker		22b. DATE SIGNED 28 May 66	
22c. PHYSICIAN'S NAME (Type) James S. SHUMAKER		22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1 Jun 66	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery
24. FUNERAL DIRECTOR Ben. Rogers		25a. ADDRESS 2847 Wilson Blvd., Ives Funeral Home Arlington, Virginia	25b. REC'D BY REGISTRAR MAY 31 1966
		25c. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

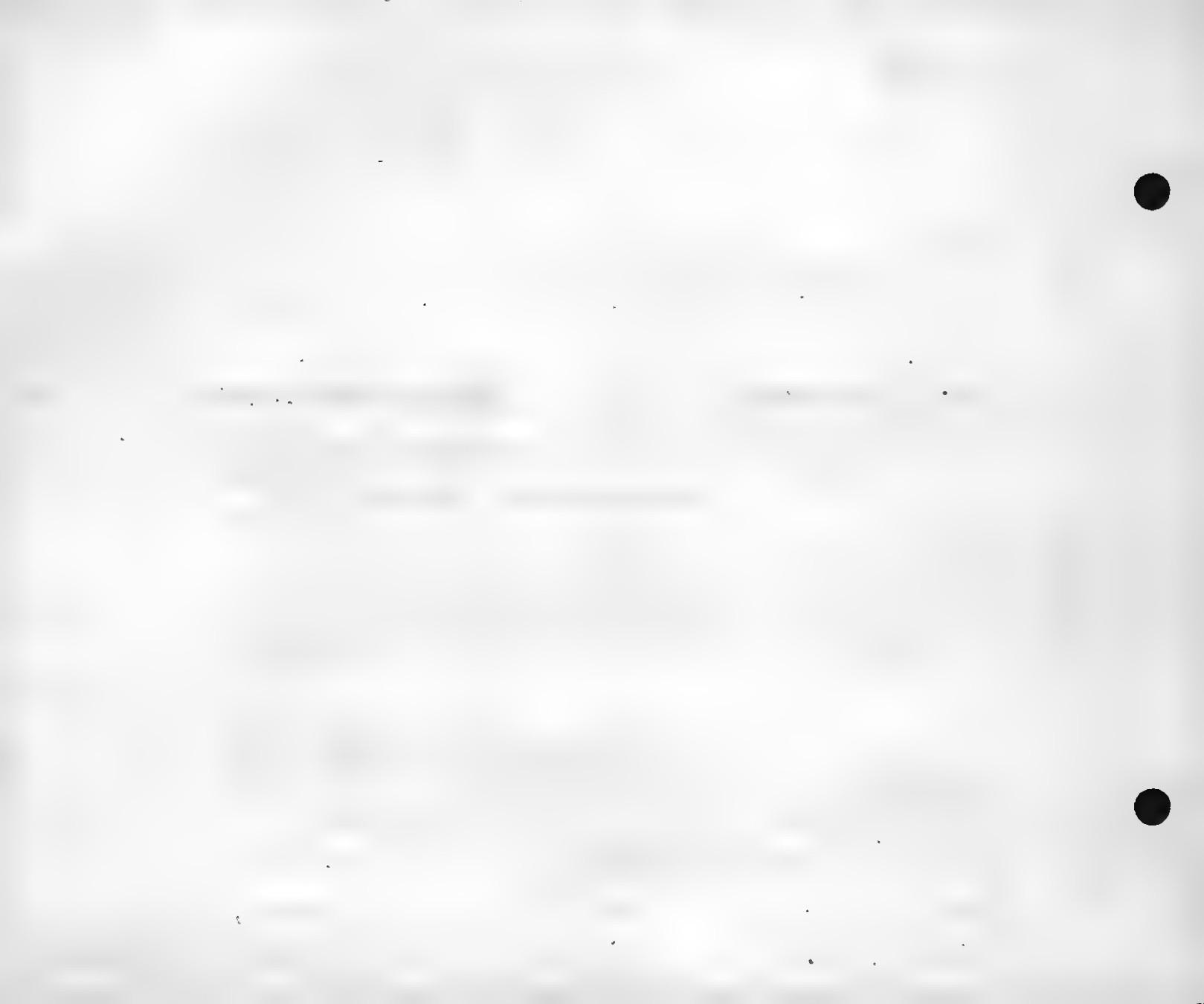
CERTIFICATE OF DEATH

57108

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<u>C7116</u>		MARYLAND											
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)											
<u>Anne Arundel</u> <u>Silver Spring</u>		a. STATE <u>MARYLAND</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY <u>Wheaton</u>											
c. LENGTH OF STAY IN 1B		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>Holy Cross</u>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First <u>Merry</u>	Middle <u>O</u>	Last <u>Ditto</u>	4. DATE OF DEATH Month <u>5</u>	Day <u>26</u>	Year <u>1966</u>						
5. SEX		6. COLOR OR RACE <u>Female</u>	white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 97 <u>10-14-66</u>	9. AGE (in years last birthday) <u>68</u> yrs.	10. IF UNDER 1 YEAR Months <u>7125 Noland Rd,</u>	11. IF UNDER 24 HRS Days <u>Falls Church, Va.</u>	12. IF UNDER 24 HRS Hours <u>Address</u>	13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Louisville, Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Wesley Albany</u>		14. MOTHER'S MAIDEN NAME <u>Lillie C. Lyons</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> None		16. SOCIAL SECURITY NO. <input type="checkbox"/> None		17. INFORMANT <u>David Albany Ditto</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO (b) <u>Miliary Tuberculosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Rockville, Maryland</u>		(County) <u>Rockville, Maryland</u>		(State) <u>Maryland</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>5/26</u> , 1966, to <u>5/26</u> , 1966, that (I) (we) last saw the deceased alive on <u>5/26</u> , 1966, and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Richard H. Polk</u>		22b. DATE SIGNED <u>5/26/66</u>											
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Polk</u>		22d. ADDRESS <u>10511 Summit Ave Kensington, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>28 May 1966</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) <u>Rockville, Maryland</u>		(State) <u>Maryland</u>					
24. FUNERAL DIRECTOR <u>Warren E. Humphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be given to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07117

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rockville

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

1300 Rockville Pike

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Month

LEONARD

B. DOGGETT, Sr.

May

24 1966

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

10-26-1891

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Auto Parking

II. BIRTHPLACE (County & State, or foregin country)

Virginia

U.S.A.

13. FATHER'S NAME

William Doggett

14. MOTHER'S MAIDEN NAME

Cole

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give war or dates of service)

578-05-7798 / Marie R. Doggett, See Item No. 2

INTERVAL BETWEEN ONSET AND DEATH

36 hours

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last. } (b)

DUE TO

(c)

Acute congestive heart failure
Acute lymphocytic leukemia 2 months

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from ... 5/10, 1966 to ... 5/24, 1966, that (I) (we) last saw the deceased alive on ... 5/24, 1966, and that death occurred at 1 PM, from the causes and on the date stated above.

22a. SIGNATURE

W.G.Hall M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED
5/24/66

22c. PHYSICIAN'S NAME (Type)

Dr. W. G. Hall

22d. ADDRESS
615 West Montgomery Ave. Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

5-27-1966

23c. NAME OF CEMETERY OR CREMATORIUM

Gate of Heaven Cemetery

23d. LOCATION (City, town or county)

(State)

Silver Spring, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC.

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JUN 2 1966

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

37110

TO HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.*Covering calls for Dr. Murphy is patriotic*
Cleared with Michael S. Murphy

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Montgomery Rockville (Hazel) 10 yrs. None		b. STATE Maryland c. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rockville (Hazel) 10 yrs. None		Rockville (Hazel) 11900 Stony Creek Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
5. SEX		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Male		f. DATE OF DEATH	
6. COLOR OR RACE		Last Month Day Year	
White		May 24 1966	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Farmer		March 6, 1896	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday)	
Farmer		70 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		10. BIRTHPLACE (County & State or foreign country)	
Farming		Virginia	
11. MOTHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
John W. Donaldson		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Elizabed Leach			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
UNKNOWN		Mrs. Rebecca Donaldson - Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		6 mos.	
Conditions, if any, which gave rise to immediate cause (b)			
(c)			
DUE TO			
DUE TO			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY		Month, Day, Year	
Hour e.m. p.m.		20d. INJURY OCCURRED	
19		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
		(State)	
21. I certify that (I) (this hospital) attended the deceased from		1964, 19, to May 24, 1966 that (we) last saw the deceased alive on 5/9 1966, and that death occurred at 10:00 PM, from the causes and on the date stated above	
22e. SIGNATURE		22f. DATE SIGNED	
W. G. Hall, M.D. for W. S. Murphy, M.D.		5/24/66	
22g. PHYSICIAN'S NAME		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
W. G. Hall, M.D. for W. S. Murphy, M.D.		22h. ADDRESS	
615 WEST MONTGOMERY AVE. ROCKVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial May 27, 1966		23c. NAME OF CEMETERY OR CREMATORIAL	
REMOVAL		Prospect Hill Cemetery Front Royal, VA.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Robt. A. Pumphrey, Bethesda, Md.		25a. REC'D BY REGISTRAR	
Pumphrey		25b. REGISTRAR'S SIGNATURE	
MAY 27 1966		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. It should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C87119

07111

CERTIFICATE OF DEATH

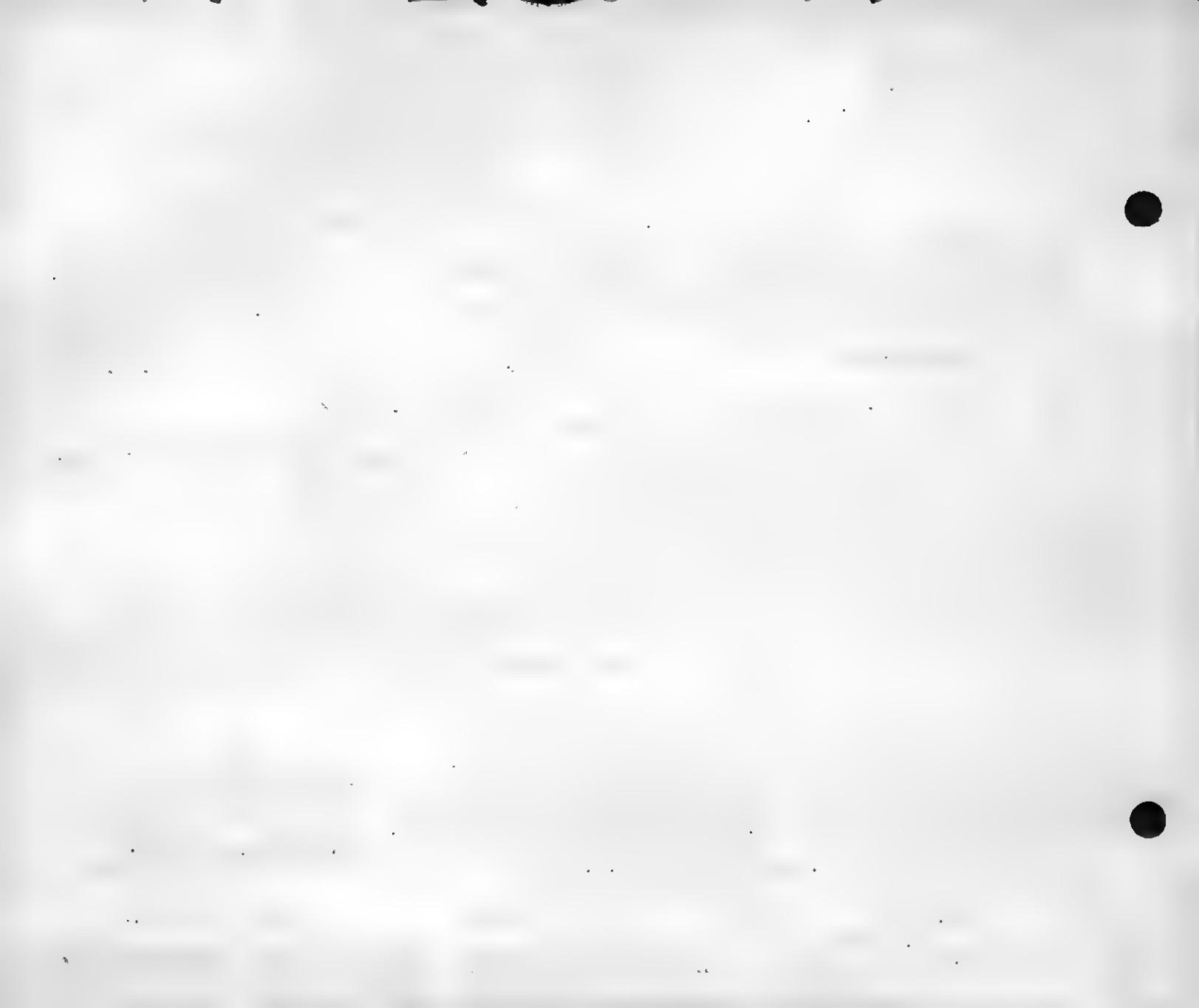
1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town)		Rensington		b. STATE		Md.	
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Coppell Hall Sanitorium		d. STREET ADDRESS		Wheaton	
3. NAME OF DECEASED (Type or print)		First Margaret	Middle E.	Last Donovan	4. DATE OF DEATH	Month May	Day 7
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 YEAR Months	11. UNDER 24 HRS Days Hours Min.
Female		White		Dec. 1, 1878	87 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
H-Wife		—		Michigan		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Ezra T. Mahone		Harriet Nichols					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
NO		None		Robert O. Donovan		S2ne 3342	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> INTERVAL BETWEEN DUE TO 31X ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Arteriosclerosis</u> 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1961, 19, to 4/29, 1966, that (I) (we) last saw the deceased alive on 4/29, 1966, and that death occurred at 1:45 A.M., from the causes and on the date stated above.		22a. SIGNATURE <u>A.W. Smith</u>					
22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) A.W. SMITH		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/66		23c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Mem. Park		23d. LOCATION (City, town or county) (State) Orlando, Fla.	
24. FUNERAL DIRECTOR W.W. Chambers Inc		ADDRESS 8655 Georgia Ave Silver Spring, Md.		25a. REC'D BY REGISTRAR MAY 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 15M 4-64							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Please sign and file with the State Dept. of Health prior to burial, cremation, or removal, and within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
Montgomery County MARYLAND				b. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. COUNTY Montgomery							
c. LENGTH OF STAY IN lb 3 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 500 Southwest Drive							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Maurice Wilson Downs				4. DATE OF DEATH Month Day Year							
First Middle Last				5 9 1966							
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14-06		9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GOVERNMENT PRINTING OFFICE - RETIRED				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Seneca Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Maurice C. Downs				14. MOTHER'S MAIDEN NAME Sarah J. Miles							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No None				16. SOCIAL SECURITY NO. YES				17. INFORMANT Leona D. Downs Address 500 Southwest Drive Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of left kidney with widespread metastases INTERVAL BETWEEN ONSET AND DEATH 180X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c) DUE TO metastases DUE TO DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (This hospital) attended the deceased from Feb. 1966 to May 1966, that (I) (We) last saw the deceased alive on May 1966, and that death occurred at 8:30 M, from the causes and on the date stated above.											
22a. SIGNATURE G. Lennard Gold				22b. DATE SIGNED 5/19/66							
22c. PHYSICIAN'S NAME (Type) G. Lennard Gold, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 8641 Colesville Road Silver Spring, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11 May 1966				23c. NAME OF CEMETERY OR CREMATORIUM Monacacy Cemetery			
24. FUNERAL DIRECTOR <i>John Thomas</i> ADDRESS Warner E. Pumphrey, Inc. Silver Spring, Md.				25a. REC'D BY REGISTRAR MAY 12 1966				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH		07113					
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. LENGTH OF STAY IN 1b <i>2 days</i>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>Maryland</i>				b. COUNTY <i>Prince George's</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross.</i>												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>							
3. NAME OF DECEASED (Type or print) <i>Francis William Dudley</i>				First		Middle		Last		8/1		4. DATE OF DEATH <i>Dudley</i>		Month <i>5</i>		Day <i>17</i>		Year <i>1966</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDOWED <input type="checkbox"/> DIVDRCED		8. DATE OF BIRTH <i>5/16/66</i>		9. AGE (In years last birthday) <i>5 yrs.</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Thomas Wm. Dudley</i>				14. MOTHER'S MAREN NAME <i>Patricia Marian Moran</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>				17. INFORMANT <i>Patricia Dudley Address 7007-24th Ave Mother Hyattsville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory distress syndrome</i> 7735 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Pneumothorax</i> (c)												INTERVAL BETWEEN ONSET AND DEATH <i>life</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5716</i>		20f. (City or town) <i>5717</i>		(County) <i>5717</i>		(State) <i>5717</i>							
21. I certify that (I) (this hospital) attended the deceased from <i>5/16/66</i> to <i>5/17/66</i> , that (I) <i>last</i> saw the deceased alive on <i>5/17/66</i> , and that death occurred at <i>5716</i> M, from the causes and on the date stated above.																			
22a. SIGNATURE <i>McDonald</i>				22b. DATE SIGNED <i>5/18/66</i>															
22c. PHYSICIAN'S NAME (Type) <i>J. F. McDonald</i>				22d. ADDRESS <i>1000 LEONARD ST. SU. 5P. MD.</i>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>				23b. DATE THEREOF <i>May 23, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>		23d. LOCATION (City, town or county) <i>Arlington, Virginia</i>				(State)							
24. FUNERAL DIRECTOR <i>Glen Carter</i>				25a. REC'D BY REGISTRAR <i>MAY 24 1966</i>								25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							
11. FUNERAL DIRECTOR <i>Warren E. Bumphrey, Inc. Silver Spring, Md.</i>																			



M
FOR STATE
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with your files. Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

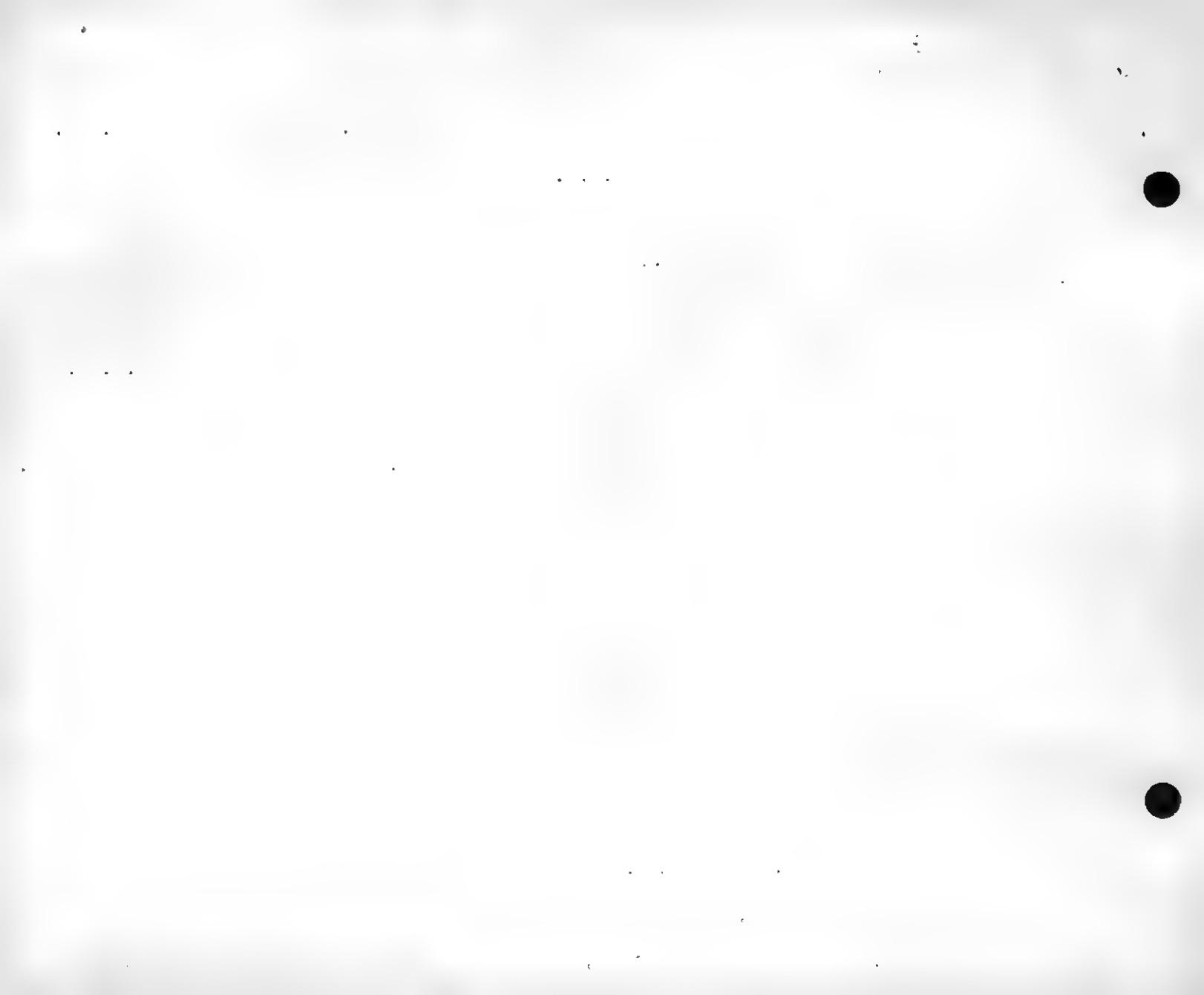
ITEMS 18-21 Film G578 // MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 2c, 3, 1va, 16, 17, 20f Film G579 8/1/66mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07114

C7122

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Mont. Co.	
c. LENGTH OF STAY IN b. D.O.A.		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS 9000- Saunders Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eleanor		First Elizabeth	Middle Dunlap
4. DATE OF DEATH Month May	Day 23	Year 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED Never married	8. DATE OF BIRTH 9/23/02
9. AGE (in years last birthday) 63 yrs	10. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richard S.unders	14. MOTHER'S MAIDEN NAME Nellie Bean	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Dunlap	Address Edward T. Pumphrey// Husband same as above
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE Drug intoxication		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Overdose of acetaminophen			
DUE TO (b)			
DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1b.) Accidentally took overdose of drug for her arthritis	
20c. TIME OF INJURY Month, Day, Year 5:30 pm 5/23 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Bethesda, Cabin John, Montg.		(County) Md.	
(State) Montgomery			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John G. Ball, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED 5/24/66			
Address (Street, city, town, or county) Bethesda, Maryland			
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial	23b. DATE THEREOF May 26, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery	23d. LOCATION (City or Town) Rockville
		(County) Maryland	
		(State) Montgomery	
24. FUNERAL DIRECTOR Robert A. Pumphrey	ADDRESS Bethesda, Maryland	25a. RECD BY REG STRR MAY 26 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

87123

CERTIFICATE OF DEATH

07115

Item 1a from 12/16/66 mh

1. PLACE OF DEATH

2. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rockville

MARYLAND

c. LENGTH OF STAY IN b.

7 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

304 Baltimore Road

First

Middle

3. NAME OF
DECEASED
(Type or print)

Maggie Virginia

Duvall

4. SEX

6. COLOR OR RACE

F

W

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

July 1, 1878

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

Home

Md.

USA

13. FATHER'S NAME

Gideon Draper Briggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give rank date of service)

NO

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (b) _____

DUE TO

Conditions, if any, which
gave rise to immediate cause
(b), stating the underlying
cause last.

Cerebral hemorrhage

Hypertensive cardiovascular disease

INTERVAL BETWEEN
ONSET AND DEATH

2 days

7 years

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

none

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 1959 to May 29, 1966 that (I) (we) last saw the deceased alive on May 29, 1966, and that death occurred at 12:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

W.H. Linnicott

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS. 22b. DATE
SIGNED
5/29/6622d. ADDRESS
110 S. Washington St. Rockville, Md.23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

23b. DATE THEREOF
June 1, 1966

Galeaville

23d. LOCATION (City, town or county)
(State)

Galeaville, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Francis H. Barber

ADDRESS
Laytonsville, Md.25e. REC'D BY REGISTRAR
JUN 3 196625b. REGISTRAR'S SIGNATURE
Charles Judge

• B. C. T. • T. L. • 1905.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7124

CERTIFICATE OF DEATH

C7116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of remains.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Md.		c. LENGTH OF STAY IN 1b 11 MONTHS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Maryland		d. STREET ADDRESS 3802 Elby Court. Wheaton, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amelia		First GLADYS	Middle Edelstein
S. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED Office	8. NEVER MARRIED <input type="checkbox"/>
9. DATE OF BIRTH Aug. 22 1901		10. AGE (in years at birthday) 60 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Office	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundal County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Philip Aaron		14. MOTHER'S MAIDEN NAME Alice Fogelman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16. SOCIAL SECURITY NO. 212-22-1150	
17. INFORMANT MARTIN EDWARDS		Address AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, RIGHT LOWER LOBE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HEMIPLAGIA, LEFT (c) CEREBRAL THROMBOSIS			
INTERVAL BETWEEN ONSET AND DEATH 5 DAYS			
5 DAYS			
5 DAYS.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woodlawn, Maryland
20f. (City or town) Woodlawn		(County) Maryland (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from 5/29 1963 to 5/11 1966 , that (II) (we) last saw the deceased alive on 5/11 1966 , and that death occurred at 4:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE James A. Roberts		22b. DATE SIGNED MAY 11, 1966	
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS		22d. ADDRESS 8907 GEO. AVE. SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 13, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Beth Tfiloh
23d. LOCATION (City or Town) Woodlawn, Maryland		(County) Maryland (State) Maryland	
24. FUNERAL DIRECTOR Sol. Levinson & Bros. Inc.		25a. RECEIVED BY REGISTRAR MAY 16 1966	
ADDRESS 6010 Reisterstown Rd.		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07117

1 C7125

2. PLACE OF DEATH
a. COUNTY

Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Kensington.

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

10225 Kensington Pky.

3. NAME OF
DECEASED
(Type or print)

First Middle
Frederick James

Last
Edwards.

4. DATE
OF
DEATH
May 9 1966

5. SEX

M.

6. COLOR OR RACE

W.

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Oct 24, 1912

9. AGE (In years
last birthday)

53 yrs.

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

RETIRED ENLISTED USA

10b. KIND OF BUSINESS OR
INDUSTRY

N/A

11. BIRTHPLACE (State or foreign country)

TEXAS

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

KENNETH MALCOLM EDWARDS (DECEASED)

14. MOTHER'S MAIDEN NAME

DAISY VIRGINIA DODSON (DECEASED)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

YES

16. SOCIAL SECURITY NO.

464-01-9242

17. INFORMANT PARKWAY, KENSINGTON, MD. APT. 708

REBECCA G. EDWARDS/WIFE/10225 KENSINGTON /

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cardio Insufficiency due to -

INTERVAL BETWEEN
ONSET AND DEATH

Stddn.

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

DUE TO

(c)

DUE TO

Cardio Vascular Disease -

Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

John G. Ball

Bethesda
7936 Old Georgetown Road, Maryland

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22. DATE SIGNED

5/9/66

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF
12 May 1966

23c. NAME OF CEMETERY OR CREMATORIUM

ARLINGTTON NATIONAL CEMETERY, ARLINGTON, VIRGINIA

23d. LOCATION (City, town or county)
(State)

24. FUNERAL DIRECTOR:

Warren E. Purphrey, Inc.

ADDRESS
8434 George Avenue
Silver Spring, Md.

25a. REC'D BY REGISTRAR
MAY 12 1966

25b. REGISTRAR'S SIGNATURE
Charles Judge

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Page 3 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if it is to be sent within 72 hours after death.

C7126

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7115

1 PLACE OF DEATH a. COUNTY MONTGOMERY		2 USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY & ID 7 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3 NAME OF DECEASED (Type or print) BENJAMIN		First AUGUST	Middle Lost ELLIN, JR
4 DATE OF DEATH May 6		Month Month 1966	Day Year
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8 DATE OF BIRTH 2-14-78		9 AGE (In years last birthday) 88 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Truck FARMER	
11 BIRTHPLACE (State or foreign country) D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJAMIN ELLIN		14. MOTHER'S MAIDEN NAME FLORENCE WILSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary embolism, massive, bilateral. DUE TO 9040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Deceased fell at home fracturing left hip.	
20c. TIME OF INJURY Month, Day, Year Ho 6 A.M. 12:30 p.m. 4/30 '66		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Silver Spring Montg Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/> MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) Montgomery, Md	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		22. DATE SIGNED May 7, 1966	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF May 9, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's		23d. LOCATION (City or Town) (County) (State) Fairland Montg Md	
24. FUNERAL DIRECTOR Arthur Velters		25a. ADDRESS 254 Carroll St	
25b. REC'D BY REGISTRAR DATE MAY 10 1956		25c. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07119

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town SILVER SPRING				c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1908 AUGUST DRIVE											
d. STREET ADDRESS 1908 AUGUST DRIVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First ALLEN	Middle M.	Last ELLIS	4. DATE OF DEATH MAY 19 1966	Month May	Day 19	Year 1966							
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5/25/1913		9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Clerk-Typist		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) (U.S.) Washington DC		12. CITIZEN OF WHAT COUNTRY? U.S.A									
13. FATHER'S NAME James Martin			14. MOTHER'S MAIDEN NAME Alice Warwick												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16. SOCIAL SECURITY NO. 577-28-5381		17. INFORMANT James W. Martin - 1908 August Drive, SS Mo		Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			PULMONARY EDEMA, ACUTE DUE TO HYPOTHYROIDISM AND MYXEDEMA DUE TO ANEMIA, ACUTE DUE TO GI BLEEDING						INTERVAL BETWEEN ONSET AND DEATH 2 MINUTES						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last			(b) HYPOTHYROIDISM AND MYXEDEMA DUE TO HEPATIC INSUFFICIENCY AND MALNUTRITION						(c) ANEMIA, ACUTE DUE TO GI BLEEDING 1 year 3 WEEKS						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that (1) (this hospital) attended the deceased from _____ 10/13 1958 to 5/19 1966, that (1) (we) last saw the deceased alive on 5/19 1966, and that death occurred at 10 AM, from the causes and on the date stated above.			22a. SIGNATURE James A. Roberts						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/19/66				
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS			22d. ADDRESS 8907 Geo. Ave. SILVER SPRING, MD.												
23a. FUNERAL CREMATION REMOVAL (Specify) Burial			23b. DATE THEREOF 5-23-1966		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery			23d. LOCATION (City, town, or county) Suitland, Md.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gowler's Sons, Inc.			ADDRESS 5150 Wisconsin Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR MAY 25 1966			25b. REGISTRAR'S SIGNATURE Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Page 3 should be detached for use as the burial-transit permit. Then please return to carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

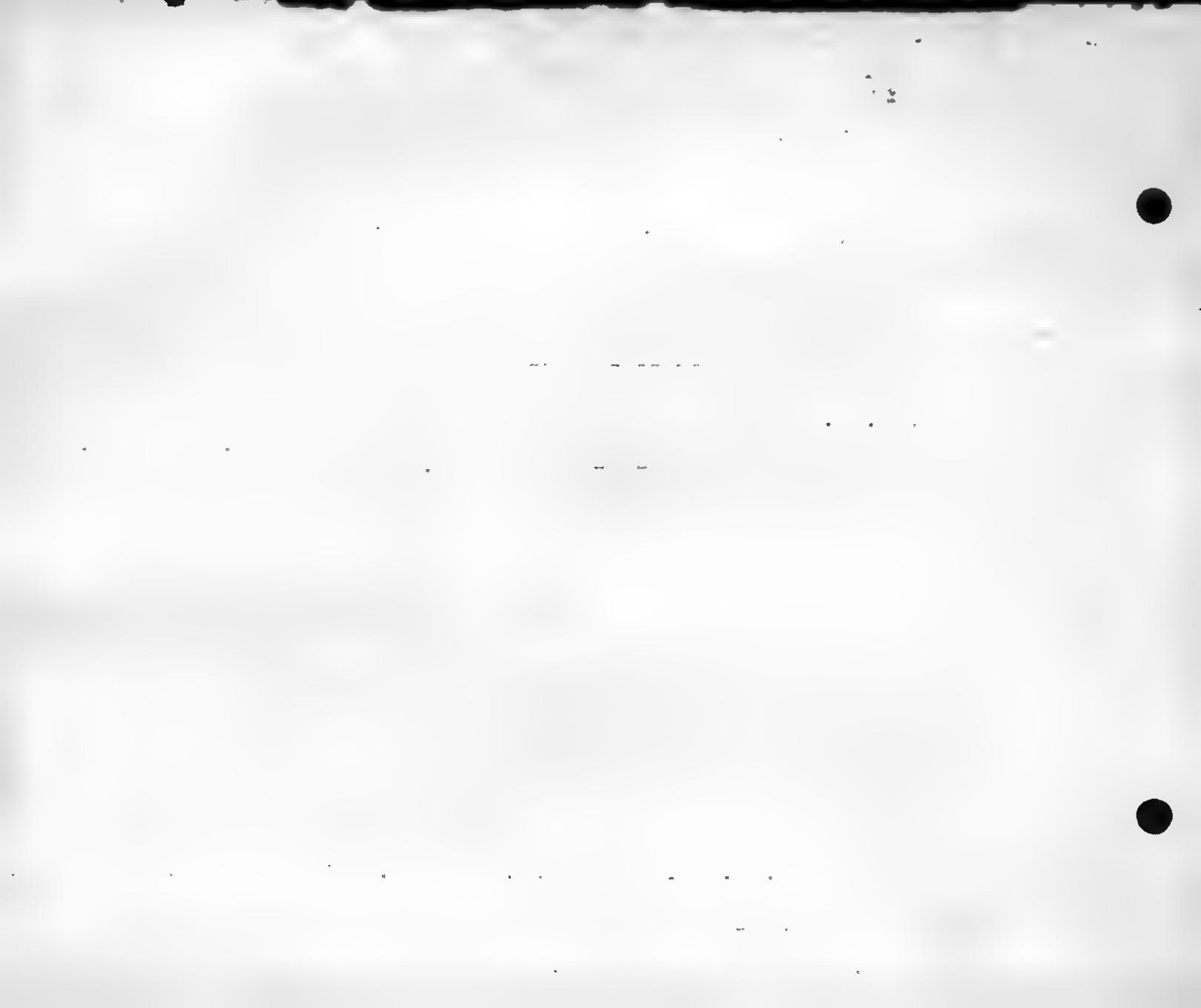


MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please handle carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH													
67128						07120							
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND b. COUNTY MONT.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			c. LENGTH OF STAY IN TB 15 MOS.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			d. STREET ADDRESS 101 EVANS STREET				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First KATHERINE	Middle O.	4. DATE OF DEATH MAY 21 1966		Month		Day		Year			
5. SEX F		6. COLOR OR RACE WHITE		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH MAY 3, 1889		10. AGE (In years last birthday) 77 yrs.			
10a. US. JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland					
13. FATHER'S NAME L. I. G. Owings						14. MOTHER'S MAIDEN NAME Ella Linthicum							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. 578-28-1639		17. INFORMANT Son John O. England		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>603X</u> DUE TO <u>Urremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Surgical loss of kidney - nephrostomy tube</u> DUE TO <u>in other kidney</u> (c) <u>4 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , to <u>5/21/66</u> , that (I) (we) last saw the deceased alive on <u>5/19/66</u> , and that death occurred at <u>2:00 P.M.</u> from causes and on the date stated above													
22a. SIGNATURE <u>W. G. Hall</u>													
22c. PHYSICIAN'S NAME (Type)		M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/21/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-66		23c. NAME OF CEMETERY OR CREMATORIAL Rockville Cemetery		23d. LOCATION (City or Town) Rockville, Maryland		(County)		(State)			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAY 25 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							
VR A15 (4) 20 M 1/66													



X 1
M TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07121

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		SILVER SPRING 29 days		a. STATE	MARYLAND		b. COUNTY
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Holy Cross Hosp.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		SILVER Spring, Md.	
3. NAME OF DECEASED (Type or print)		First DOROTHY	Middle C	Last FRICKSEN	4. DATE OF DEATH	Month 5	Day 4 Year 1966
5. SEX F		6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/89	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 77 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Post Ret. Comptometer Operator US S. Office		11. BIRTHPLACE (County & State, or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Lubel Wallette		14. MOTHER'S MAIDEN NAME Denise Boudreaux					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No None		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Dolores J. Malaszefski		Address 331 Clay Street Wheaton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Pulmonary Embolus 170X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Thrombo phlebitis DUE TO (c) Disseminated Lung carcinoma of Breast		INTERVAL BETWEEN ONSET AND DEATH minutes days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1965 to May 1966, that (I) (we) last saw the deceased alive on May 1966, and that death occurred at 10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE G. Lennard Gold						22b. DATE SIGNED 5/5/66	
22c. PHYSICIAN'S NAME (Type)		G. Lennard Gold, M.D.		22d. ADDRESS 8641 Colesville Rd. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9 May 1966		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR John Thomas Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR MAY 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Part 1, Part 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film G379 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH 07122

1. PLACE OF DEATH a. COUNTY		Items 8, 9 Film G379 5-17-66 wh		2. USUAL RESIDENCE [Where deceased lived, if institution: Residence before admission]		
Montgomery				a. STATE	b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				Maryland	Montgomery	
Silver Spring		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		
		4 days		GARRETT PARK		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		
Holy Cross Hospital				4900 STRATHMORE AVE.		
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year	
Leila				5	8 1966	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday) IF UNDER 1 YEAR	
F		W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1890 9/13/1966	75 73 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
House Keeper				IOWA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY		
Unknown		Unknown		U.S.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give rank or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address		
No		472-24-1848		Hospital Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Left coronary artery thrombosis;				
7/20/		DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	Coronary atherosclerosis			
		DUE TO				
		(c)	Arteriosclerotic heart disease.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)	
19						
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
BELDEN		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> R. REPP, M.D. Wheaton				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		DATE SIGNED		
Bur-Transit		5/12/66		May 8, 1966		
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)		
Hillside		Platteville, Wisconsin				
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		
Tyson Wheeler Funeral Home		1331 Rockville Pike		24b. REGISTRAR'S SIGNATURE		
		Rockville, Maryland		MAY 10 1966 Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

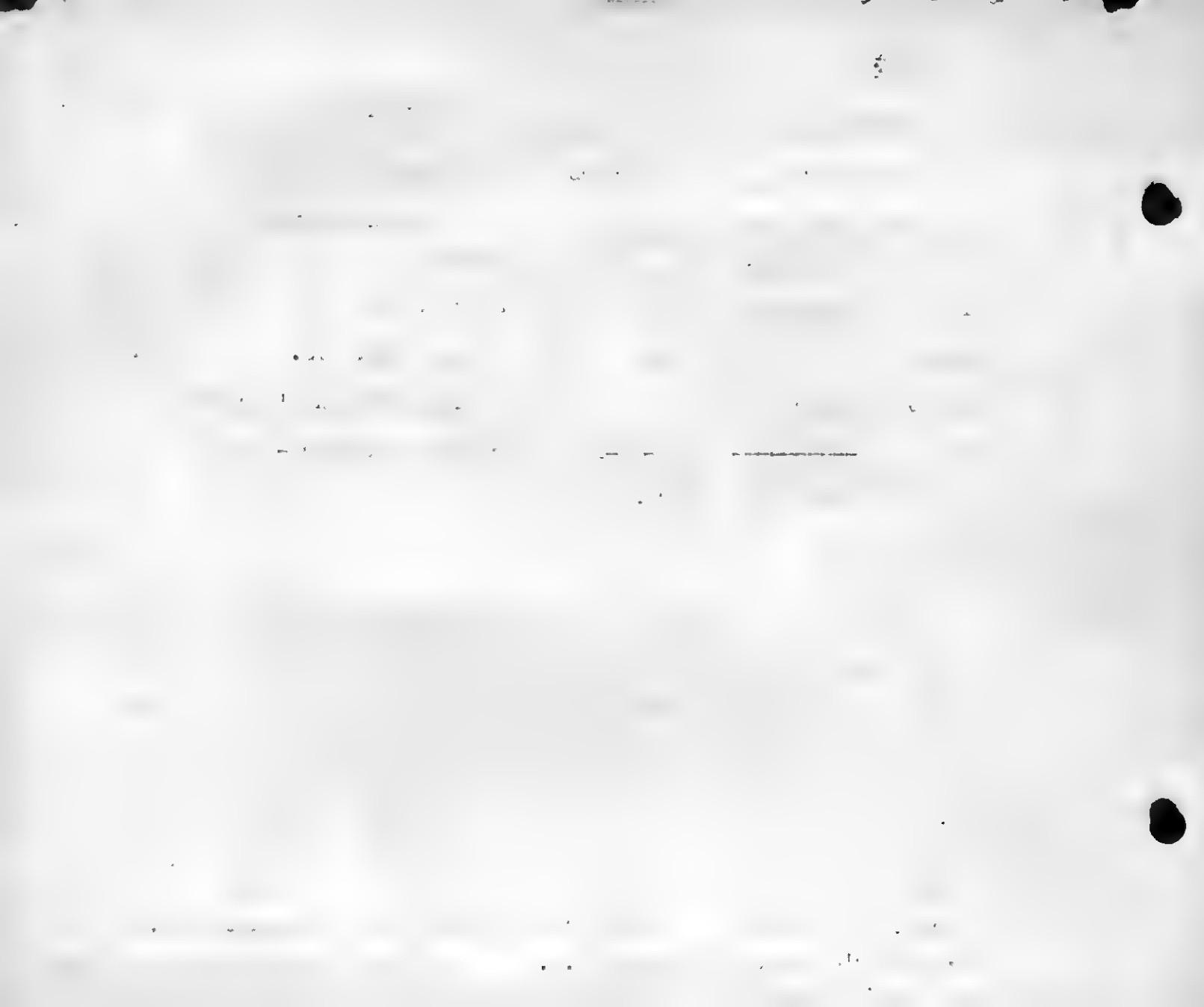
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7131

CERTIFICATE OF DEATH

C7123

1. PLACE OF DEATH e. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3809 Club Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EDWARD	Middle NMI	Last FISCHER
4. DATE OF DEATH May 26	Month May	Day 26	Year 1966
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney	10b. KIND OF BUSINESS OR INDUSTRY Law	9. AGE (in years at birth) 78	11. BIRTHPLACE (County & State, or foreign country) Deerbrook, Wis.
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME John B. Fischer		
14. MOTHER'S MAIDEN NAME Elizabeth Von O'Stransky	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. 220-44-1936	17. INFORMANT Marguerite Fischer - Same as # 2	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO Pain in rectum, carcinoma, prostate Infiltrative carcinoma			
INTERVAL BETWEEN ONSET AND DEATH 7 1/2 years			
3 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1, 1966 , to May 26, 1966 , that (I) (we) last saw the deceased alive on May 26, 1966 , and that death occurred at 4 PM , from the causes and on the date stated above.			
22a. SIGNATURE Frank R. Shea		22b. DATE SIGNED May 26, 1966	
22c. PHYSICIAN'S NAME (Type) FRANK R. SHEA		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 4100 - 22nd St. NE Wash DC 20018	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rock Creek Cemetery
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Washington, D.C.		25a. REC'D BY REGISTRAR JUN 3 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



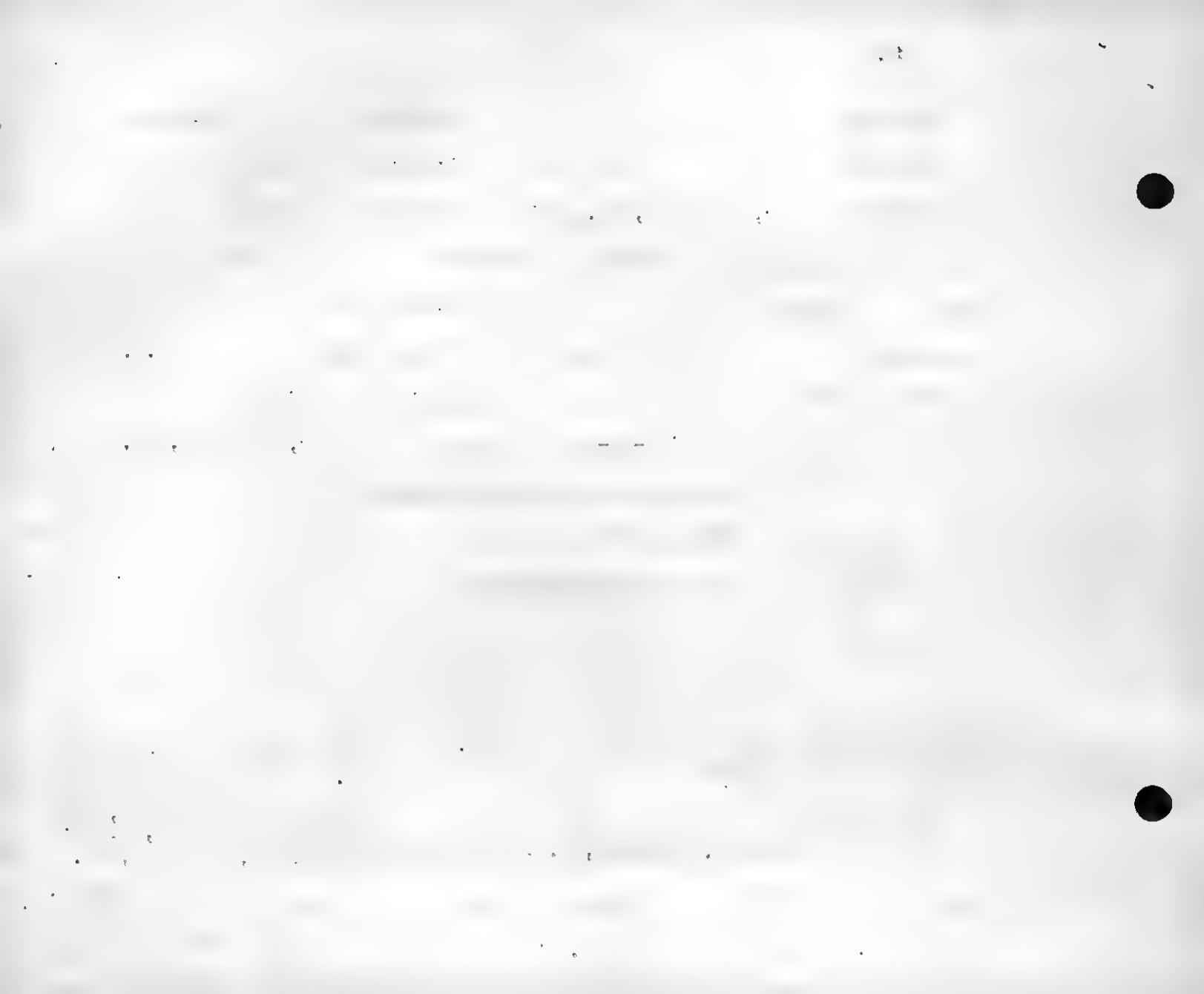
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then place ~~3~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17132		C7124										
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b 43 days										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		e. STREET ADDRESS 502 East 38th Street										
3. NAME OF DECEASED (Type or print)		First John	Middle William	Last Forshaw	4. DATE OF DEATH Month May	Day 3	Year 1966					
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED NEVER MARRIED	8. DATE OF BIRTH 10b. KIND OF BUSINESS OR INDUSTRY Unascertainable	9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months 2	Days 13	Hours 13	IF UNDER 24 HRS. Minutes 13			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania										
13. FATHER'S NAME Albert Forshaw		12. CITIZEN OF WHAT COUNTRY? U.S.A.										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. 173-09-6339		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Md. 20014						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraoperative Aortic Dissection												
410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral Stenosis												
DUE TO (c) Rheumatic Heart Disease												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED at work White		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at work Not White		20f. (City or town) (County) (State)						
21. I certify that (this hospital) attended the deceased from March 21, 1966 , to May 3, 1966 , that (we) last saw the deceased alive on May 3, 1966 , and that death occurred at 1:35 P.M. , from the causes and on the date stated above.												
22a. SIGNATURE Douglas M. Behrendt		22b. DATE SIGNED May 4, 1966										
22c. PHYSICIAN'S NAME (Type) Douglas M. Behrendt, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/1966		23c. NAME OF CEMETERY OR CREMATORY Mound Cemetery		23d. LOCATION (City, town or county) Williamsport, Lycoming Co.		(State) Penn				
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR MAY 6 1966										25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 2DM 1/65												



FOR STATE
HEALTH DEPT.

24 1 M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

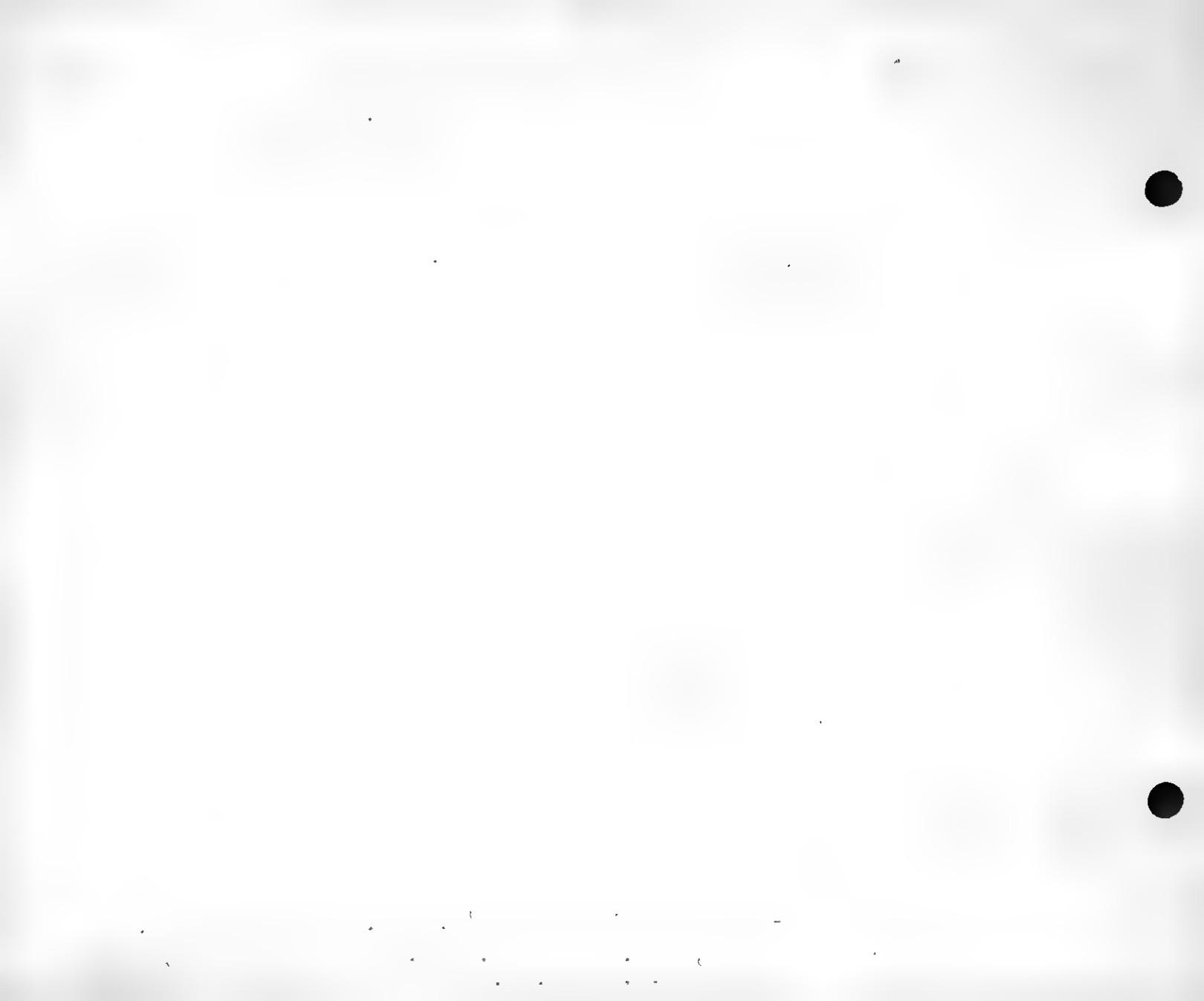
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27133 G7125

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURA and give nearest town) Bethesda		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Md. b COUNTY Montgomery		
c LENGTH OF STAY IN '66 5601 Newington		c CITY OR TOWN (If outside corporate limits, write RURA and give nearest town) Bethesda		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5601 Newington		d STREET ADDRESS 5601 Newington Rd.		
e S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) William Henry Fortines	FIRST W.	MIDDLE H.	LAST Fortines	
4 DATE OF DEATH May 11 1966	Month	Day	Year	
5 SEX M.	6 COLOR OR RACE W.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-13-1916	
9 AGE (In years lost birthday) 49 yrs	10 IF UNDER 1 YEAR Months	11 IF UNDER 24 HRS Days	12 IF UNDER 24 HRS Hours	
10a US. OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate	10b KIND OF BUSINESS OR INDUSTRY Real Estate	11 BIRTHPLACE (State or foreign country) Alabama	12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME William Henry Fortines Sr.	14 MOTHER'S MAIDEN NAME Ouida Holman	Address		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) yes WWII	16 SOCIAL SECURITY NO - - -	17 INFORMANT Wife - Mary Ellen	18 CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Barbiturate - Poisoning DUE TO 9702 Conditions, if any which gave rise to immediate cause (o), stating the underlying cause lost. (b) overdose of - Nebutal (c)	INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (o) 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Took over dose of Nebutal & Sed. amytal			20c PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20d TIME OF INJURY Month, Day, Year 12:30 pm 5/11 1966	20e INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20f (City or town) Bethesda, Mont. Md.	(County) Montgomery	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John G. Bell</i>	MD	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 5/11/66	
EXAMINER'S NAME (Type) Joseph Jawler's Sons, Inc.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a BURIAL, CREMATION REMOVAL (Specify) BURIAL				
23b DATE THEREOF 5-16-1966	23c NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l. Cem.	23d LOCATION (City or Town) Arlington	(County) Va.	
24. FUNERAL DIRECTOR Joseph Jawler's Sons, Inc.	ADDRESS 5130 Wisc. Ave. N.W. Wash. DC.	25a REC'D BY REGISTRAR MAY 13 1966	25b REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

Items 18&21 Film 380

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67126

77134

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY COUNTY MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

TAKOMA PARK

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WASHINGTON SANITARIUM HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First VIOLA MIDDLE MN

Last FRANK

4. DATE
OF
DEATH

MAY 27

1966

5. SEX

F 6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

11/20/96

9. AGE (In years
last birthday)

69 yrs.

10. UNDER 1 YEAR

Months

11. UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

Albert K. Fratik

Address

HUSBAND Same as above

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

491X

Bilateral bronchopneumonia associated

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

with septicemia and fractured lumbar vertebra

19. WAS AUTOPSY
PERFORMED?

YES NO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 19

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry , and in my opinion

death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE *Belden R. Reap* CHIEF MEDICAL EXAMINER

EXAMINER'S NAME (Type) *BELDEN R. REAP MD Washington* M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)

22. DATE SIGNED *May 28, 1966*

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL

Burial 5/31/66 Ft. Lincoln Cemetery Prince Georges County, Md.

24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

The S.H. Hines Company-Washington, D. C. JUN 2 1966 Charles Judge

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in the event of death within 72 hours after death.

VR A15ME
3500 4-64



1
FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07127

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL)		c. LENGTH OF STAY IN 1b		a. STATE		Md.		
BETHESDA		4 days.		b. COUNTY		Montgomery		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Suburban HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		chevy Chase.		
3. NAME OF DECEASED (Type or print)		First	TALIMAN	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Fe.		W.	WIOOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/26/57	8 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Student		Child		Minnesota		U.S.A.		
13. FATHER'S NAME		Donald M. Fraser		14. MOTHER'S MAIDEN NAME		Arvonne Skelton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
(If yes give war or dates of service)		00000000000		Donald M. Fraser, same item #2 (father)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration & Contusion of Brain INTERVAL BETWEEN ONSET AND DEATH 4 days								
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause first.		OUE TO (b) Multiple Injuries from colliding with Auto DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Stuck by Auto when Crossing Street -								
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. 5/20 1966 p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street -		20f. (City or town) Chevy Chase Mont. Md.	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John G. Ball JOHN G. BALL 7936 Old George Bethesda, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 5/24/66		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5/25/66		23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		23d. LOCATION (City, town or county) Prince Geo. Co., Md.		
24. FUNERAL DIRECTOR TYSON WHEELER		1331 Rockville ^{ADDRESS} Rockville, Maryland		25a. REC'D BY REGISTRAR MAY 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with Page 3. Page 5 may be retained for your files.

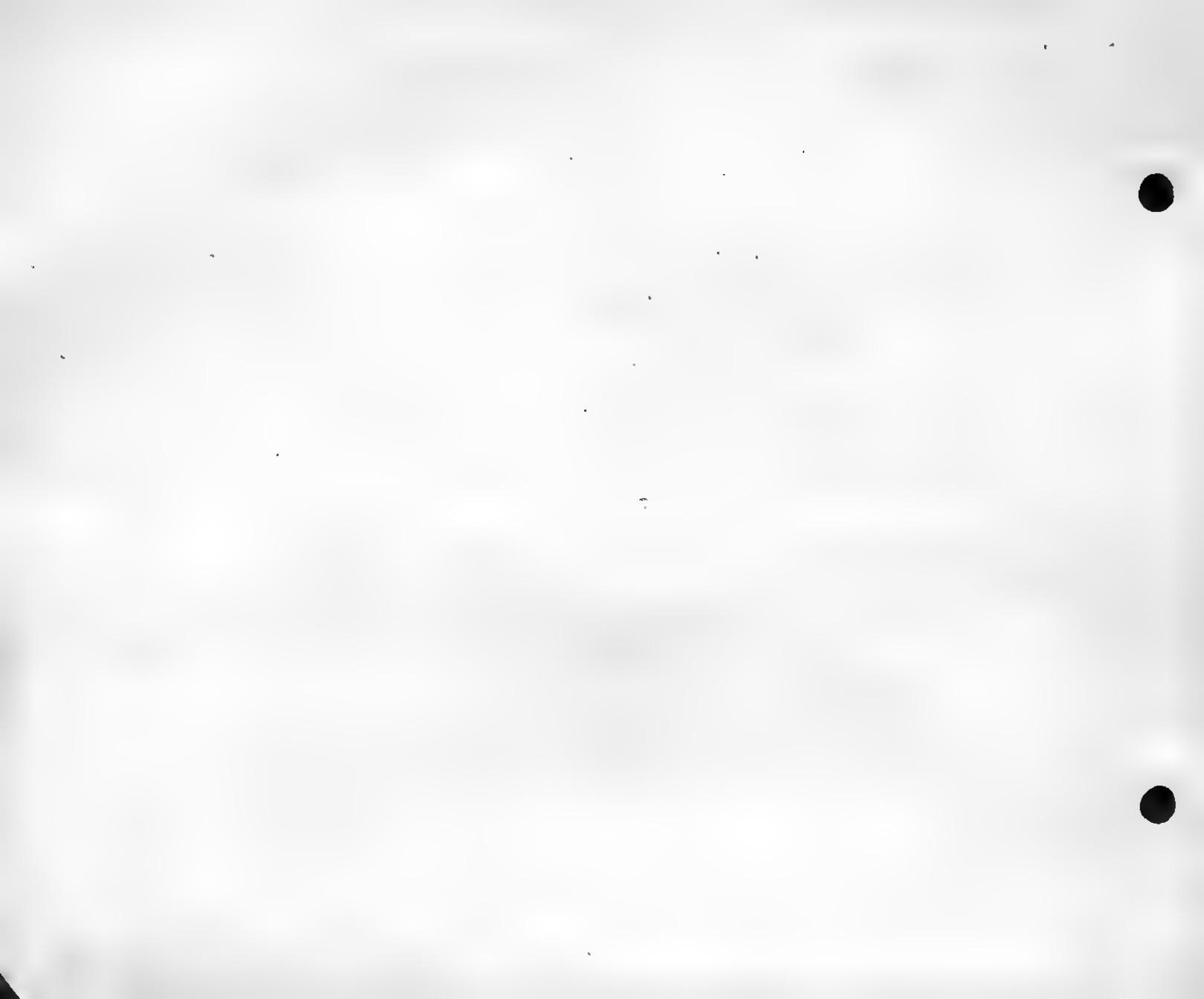


MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH		37128	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS 9495 McArthur Blvd.	
e. FIRST, MIDDLE, LAST NAME OF DECEASED (Type or print) William H. Frazier		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M.		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-2-93	
9. AGE (In years last birthday) 73 yrs		10. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Frazier		14. MOTHER'S MAIDEN NAME Katherine Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Retired		16. SOCIAL SECURITY NO. Address	
17. INFORMANT Son - Wilson - Same		18. CAUSE OF DEATH (Enter an y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart condition of previous	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) due to		INTERVAL BETWEEN ONSET AND DEATH Feb. 1965	
(b) due to		(c) due to	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Chevy Chase, Md. (County) Montgomery (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from October 10, 1965 to May 26, 1966 , that (I) (we) last saw the deceased alive on May 25, 1966 and that death occurred at 1:50 AM , from causes and on the date stated above.			
22a. SIGNATURE Donald Q. Ekman		22b. DATE SIGNED 3/26/66	
22c. PHYSICIAN'S NAME (Type) Donald Q. Ekman		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/66	
23c. NAME OF CEMETERY OR CREMATORIAL Sperryville		23d. LOCATION (City or Town) Sperryville (County) Va. (State) Va.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		26a. ADDRESS 1531 Rockville	
		26b. REC'D BY REGISTRAR MAY 31 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any
please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral
director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 3. Page 5 may be retained
by the funeral director or its designated agent, prior to burial, cremation, or removal, and in all events within 72 hours after death.

C7137

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07129

1. PLACE OF DEATH
a. COUNTY

MONTGOMERY

b. CITY OR TOWN (If outside corporal's limits
write RURAL and give nearest town)

OLNEY

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MONTGOMERY GENERAL HOSPITAL

First

M dd'

3. NAME OF
DECEASED
(Type or print)

EVANS

5. SEX

Male

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Landscaper

13. FATHER'S NAME

LLOYD GAITHER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

NO

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Acute Cerebro-vascular
hemorrhage; Essential
Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)22a. BURIAL, CREMATION, OR
REMOVAL (Specify)

23. FUNERAL DIRECTOR

ADDRESS

Robert R. Snowden Rockville, Md.

22b. DATE THEREOF

5/23/66

Brown Chapel

Dayton, Md.

22c. NAME OF CEMETERY OR CREMATORIAL

Address, street, city, town, or county

22d. LOCATION (City, town, or country)

DATE SIGNED

24a. REC'D BY REGISTRAR

MAY 25 1966

Charles Judge

24b. REGISTRAR'S SIGNATURE

1

2

3

4

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

C7138

CERTIFICATE OF DEATH

07130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN lb Riverdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium Hospital			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6109 43rd Street		
3. NAME OF DECEASED (Type or print) HARRY			4. DATE OF DEATH First Middle Last Month Day Year M. GARBER Sr. May 27, 1966		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED X	NEVER MARRIED DIVORCED □	B. DATE OF BIRTH July 4, 1895	9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S.P.O.			10b. KIND OF BUSINESS OR INDUSTRY U.S. Goverment		
11. BIRTHPLACE (County & State or foreign country) Illinois			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jacob Garber			14. MOTHER'S MAIDEN NAME Elizabeth Whorey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO 217 42 4211		
17. INFORMANT Mary W. Garber Same as #2 (wife)			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> INTERVAL BETWEEN ONSET AND DEATH 3 days					
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumonia, fibrosis</i> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3100 30th St N.W. Wash DC	20f. (City or town) Colmar Manor, P.G. Md.	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/28/66 to 5/27/66 , that (I) (we) last saw the deceased alive on 3/27/66 and that death occurred at M , from causes and on the date stated above.					
22a. SIGNATURE <i>Herbert W. Weeks Jr.</i>			22b. DATE SIGNED 1000 30th St N.W. Wash DC		
22c. PHYSICIAN'S NAME (Type) Herbert W. Weeks Jr.			22d. ADDRESS 1000 30th St N.W. Wash DC		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/66	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln	23d. LOCATION (City or Town) Colmar Manor, P.G. Md.	(County) (State)
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.			ADDRESS Francis Gasch's Sons Hyattsville, Md.	25a. RECD BY REGISTRAR JUN 3 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7139

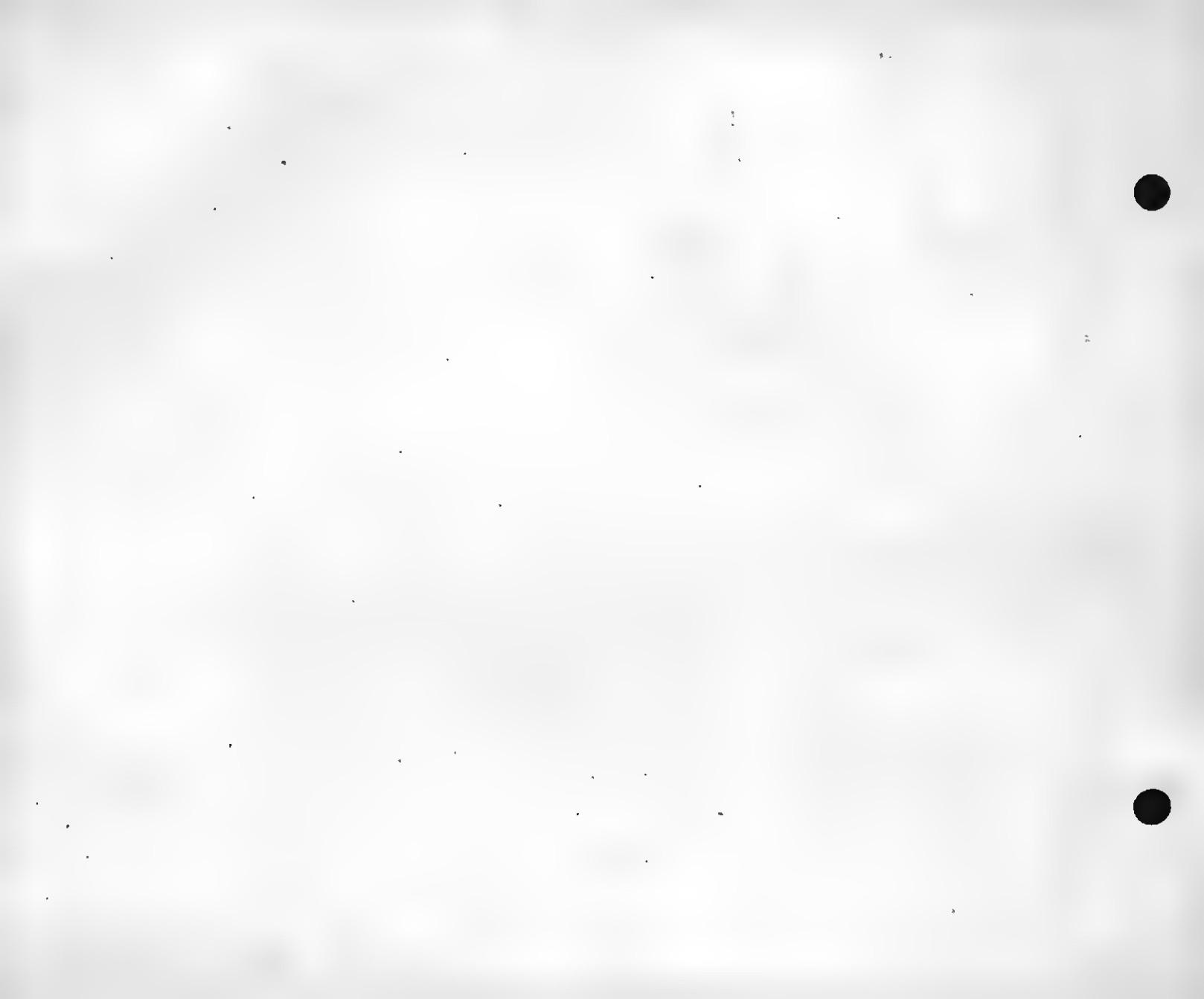
CERTIFICATE OF DEATH

C7131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH b. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Montgomery County MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Silver Spring	7 days	Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS		
Holy Cross Hospital	812-Kenbrook Drive		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Male	Andrew	Gardner	May 24
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-6-98
9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
68 yrs.	COMPTROLLER - RETIRED	Germany	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		DANIEL SCHATZ-812 KENBROOK DR. MD.	S.S.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Caducal</u> , <u>Toussaint</u>			
+201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured Myocardial</u> (c) <u>Ante Myocardial Infarction</u>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from <u>24 May 1966</u> to <u>24 May 1966</u> , that (I) (we) last saw the deceased alive on <u>24 May 1966</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
<u>WALTER E. Goode</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	5-25-66
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
WALTER E. Goode MD.		2390 GLENMONT CIR. WHITEHAVEN 4A	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL
BURIAL		5-27-66	TEMPLE BETH-EL CEM. WHITESBORO - N.Y.
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D BY REGISTRAR
B. DANZANSKY & SONS		WASHINGTON DC	25b. REGISTRAR'S SIGNATURE
			CHARLES JUDGE
			MAY 27 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		57133		
1. PLACE OF DEATH e. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland					d. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					c. LENGTH OF STAY IN 1b 12 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital										d. STREET ADDRESS 11509 Soward Drive				
3. NAME OF DECEASED (Type or print)		First Joan	Middle Frances	Last Geldner	4. DATE OF DEATH Month May		Day 30	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1962	9. AGE (In years last birthday) 3 yrs.		10. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John Franklin Geldner		14. MOTHER'S MAIDEN NAME Mildred Hogan		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT John J. Geldner		Address 11509 Soward Drive Wheaton, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic CARCINOMA										INTERVAL BETWEEN ONSET AND DEATH				
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY(Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (This-hospital) attended the deceased from 5/20 , 19 66 , to 5/30 , 19 66 , that (I) (we) last saw the deceased alive on 5/20 19 66 , and that death occurred at 4 PM , from the causes and on the date stated above.										22b. DATE SIGNED				
22a. SIGNATURE <i>J. Franklin Geldner</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												
22c. PHYSICIAN'S NAME (Type) Marvin N. Treier Jr.		22d. ADDRESS 2401 Blue Ridge Ave												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 3, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City, town or county) (State)								
24. FUNERAL DIRECTOR John B. Thomas		ADDRESS 8434 Georgia Avenue		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge								
VR A15 (4) 20M 1/65		DATE JUN 3 1966												



FOR STATE
HEALTH DEPT

C7142

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7132

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased resided, if institution Residence before admission) a STATE <i>MARYLAND</i> M ✓			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>		d STREET ADDRESS <i>8514 Greenwood Ave</i>			
e S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <i>Donald L. German</i>		First <i>INFANT MALE</i>	Middle <i>GERMAN</i>		
4 DATE OF DEATH <i>5 8 1966</i>		Month <i>5</i>	Day <i>8</i>		
5 SEX <i>MALE</i>		6 COLOR OR RACE <i>Caucasian</i>	7 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8 DATE OF BIRTH <i>5/7/66</i>		9 AGE (In years last birthday) yrs <i>0</i>	10 UNDER 1 YEAR Months <i>0</i>		
10a US. AT OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		
12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13 FATHER'S NAME <i>DONALD L. GERMAN</i>			
14 MOTHER'S Maiden NAME <i>ROBERTA L. GARNER (GERMAN)</i>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service <i>No</i>			
16 SOCIAL SECURITY NO. <i>-</i>		17 INFORMANT <i>HOSPITAL RECORDS</i>	Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Fetal anoxia, secondary to severe</i> DUE TO <i>1644</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <i>maternal toxemia of pregnancy.</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d INJURY OCCURRED While <input type="checkbox"/> Not While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) <i>(County)</i>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Belden R. Peeples</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		22. DATE SIGNED <i>May 8, 1966</i>	
EXAMINER'S NAME (Type) <i>BELDEN R. PEOPLES, M.D., Atlanta</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) <i>Springfield</i>		23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b DATE THEREOF <i>5-9-66</i>		23c NAME OF CEMETERY OR CREMATORIUM <i>Gate of Heaven Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Springfield</i>	
24. FUNERAL DIRECTOR <i>Francis Reilly 3821-147L 8th and Wash DC</i>		ADDRESS		25a REC'D BY REGISTRAR DATE <i>MAY 10 1966</i>	
				25b REG. STAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

57142

CERTIFICATE OF DEATH

57134

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Montgomery		a. STATE D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Wheaton Nursing Home		6812 Laurel N.W.-Wash.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
Emory		Last Month Day Year	
M		5 28 1966	
6. COLOR OR RACE		6. COLOR OR RACE	
W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
School TEACHER		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William J. Girdner		Amelia Shirah	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) (If yes give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
HOSPITAL RECORDS		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		1/28 -- death - 28	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Brucellosis, pneumonia	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Monocytic leukemia	
DUE TO (b)		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	
20d. INJURY OCCURRED at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
		(State)	
21. I certify that (I) (this hospital) attended the deceased from June 1965, to May 1966, that (I) (we) last saw the deceased alive on June 19, 1965, and that death occurred at 12:00 P.M. from the causes and on the date stated above			
22a. SIGNATURE		22b. DATE SIGNED	
Lee Funeral Home		22b ADDRESS	
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5-23-66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)	
Lee's Crematory Washington, D.C.		Washington, D.C. (State)	
24 FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		25a. REC'D BY REGISTRAR JUN 2 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07135

1 C7143		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
a. COUNTY Montgomery MARYLAND		b. STATE MD b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12907- MORAY RD.		d. STREET ADDRESS 12907- MORAY RD.	
3. NAME OF DECEASED First LILLIS Middle		4. DATE OF DEATH Month MAY Day 5 Year 1966	
5. SEX Male 6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-27-80		9. AGE (in years) 86 yrs. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ict - MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Russ, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Bernard Goldberg-2907 Moray Rd., Wheaton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 14 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS CEREBRAL ATHEROSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED 9/27/63 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 515 66	
21. I certify that (I) (this hospital) attended the deceased from 5/2/66 to 5/2/66, that (I) (we) last saw the deceased alive on 5/2/66, and that death occurred at 12 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 5/5/66	
22a. SIGNATURE David Goldenberg		22b. DATE SIGNED 5/5/66	
22c. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG		22d. ADDRESS 10620 GEORGINA, SILVER SPRINGS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Lebanon Cemetery		23d. LOCATION (City, town or county) (State) Ridgewood, New York	
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SON 3501 14th St. N.W., D.C.		25a. ADDRESS WASHINGTON, D.C.	
		25b. REC'D BY REGISTRAR MAY 9 1966	
		25c. REGISTRAR'S SIGNATURE Charles Judge	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)								
Montgomery			a. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			b. COUNTY Montgomery								
c. LENGTH OF STAY IN 1B 1 day - 16 hrs - 45 min											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital/give street address) Washington Sanitarium & Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Isidore Meyer Goldstein			4. DATE OF DEATH Month Day Year								
5. SEX Male White			May 16, 1966								
6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. May 16, 1894 72 yrs. Months Days Hours Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Merchandise Mgr.			10b. KIND OF BUSINESS OR INDUSTRY								
13. FATHER'S NAME Moses Goldstein			11. BIRTHPLACE (County & State, or foreign country) Roumania								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			12. CITIZEN OF WHAT COUNTRY? U.S.A.								
16. SOCIAL SECURITY NO.			17. INFORMANT Address								
Hospital Records			17600 Carroll Ave.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive cerebral embolus											
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.			DUE TO (b) due to Thrombosis 12 hr. 12 hr.								
			DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>								
20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from May 14, 1966, to May 16, 1966, that (I) (we) last saw the deceased alive on May 15, 1966, and that death occurred at 1:45 PM, from the causes and on the date stated above.			22b. DATE SIGNED May 16, '66								
22a. SIGNATURE Gene U. Cohen MD			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								
22c. PHYSICIAN'S NAME (Type) GENE U. COHEN, M.D.			22d. ADDRESS 1106 SPRING ST. SUITE NO. 100								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 5-17-66								
23c. NAME OF CEMETERY OR CREMATORIAL KING DAVID MEMORIAL GARDEN - FALLS CHURCH VA			23d. LOCATION (City, town or county) (State)								
24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS - WASIT. DR.			ADDRESS 9501-14th St. NW REC'D BY REGISTRAR MAY 19 1966								
			25d. REGISTRAR'S SIGNATURE Charles Judge								



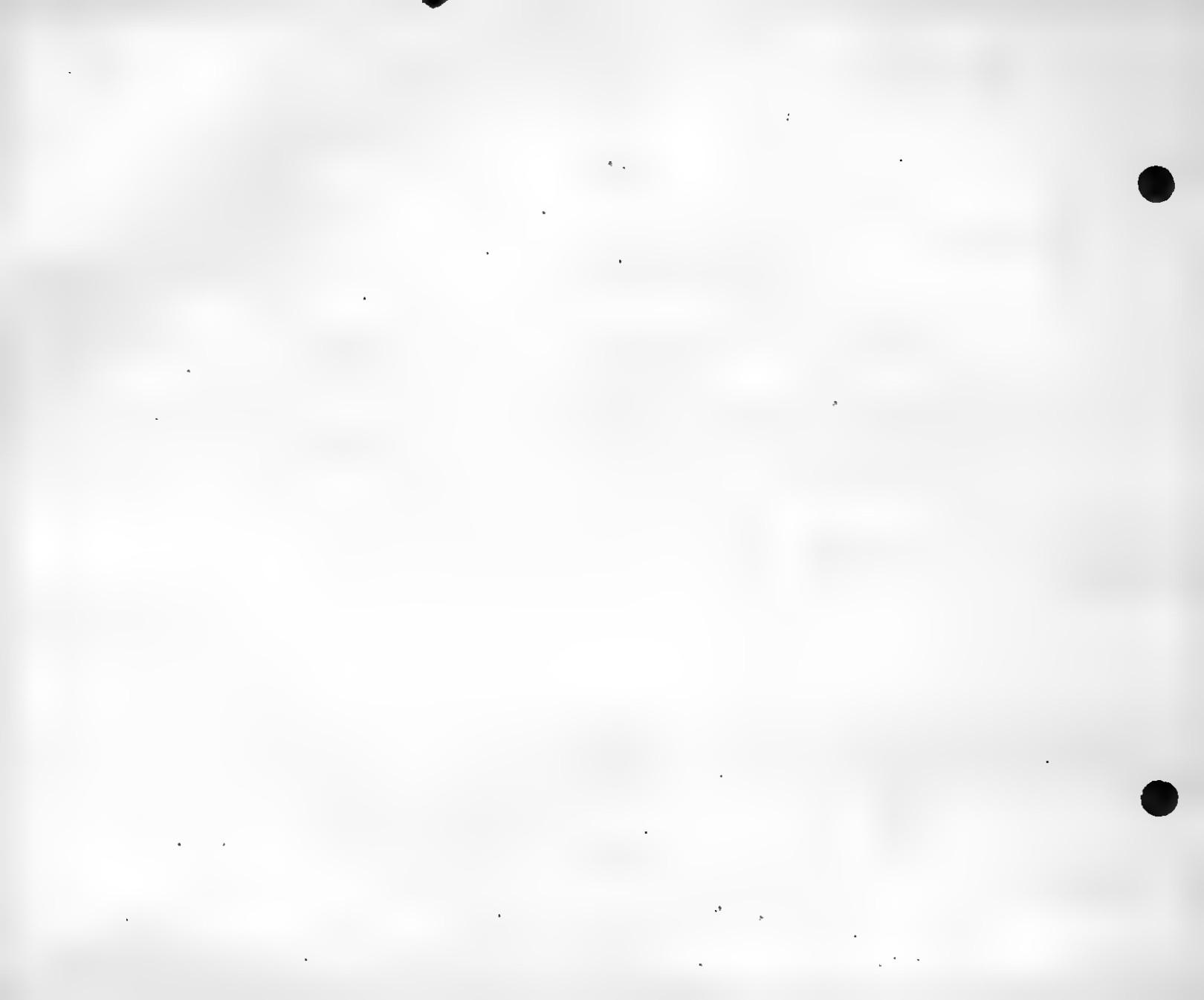
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Montgomery		Maryland	
b. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb (NineTeen) 19 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanatorium + Hospital		silver springs	
3. NAME OF DECEASED (Type or print)		First	Middle
Emily Deloach			Goodrich
4. DATE OF DEATH		Month	Day
May 4		Year	1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
F		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Hswf.		Own Home	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
St Louis, Missouri		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Virgil Deloach		Estelle Schwimmer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
Unknown		Daughter - Mrs. Joan Buckalew	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Lymphatic Leukemia 6 yrs	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from _____, 1960, to May 4, 1966, that (I) (we) last saw the deceased alive on May 4, 1966, and that death occurred at 11:30 PM, from the causes and on the date stated above.		22b. DATE SIGNED 5-5-66	
22a. SIGNATURE Philip E. Jones		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Philip E. Jones MD	22d. ADDRESS 809 Pershing Drive Silver Spring Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 9, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery
24. FUNERAL DIRECTOR Ollie Earle		ADDRESS 8434 Georgia Avenue	25a. REC'D BY REGISTRAR MAY 9 1966
Warner E. Pumphrey, Inc.		Silver Spring, Md.	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived) f. institution Residence before admission a. STATE D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY N 16		c. CITY OR TOWN (If auto de corporate limits, write RURAL and g ve nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9617 Dilston Rd.				d. STREET ADDRESS 2705 13th ST. N.E., Apt 42	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Eddie	Middle Lee	Last Green	4. DATE OF DEATH May 28, 1940	Month May Day 25 Year 1966
S. SEX M	6. COLOR OR RACE C	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 28, 1940	9. AGE (In years last birthday) 25 yrs
10. DO US-JAL OCCUPATION (G ve kind of work done during most of working life, even if ret red) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Buena Vista, Arkansas	
13. FATHER'S NAME Leroy Green		14. MOTHER'S MAIDEN NAME Laura Marie Hicks		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <input checked="" type="checkbox"/> If yes g ve war or dates of service		16. SOCIAL SECURITY NO		17. INFORMANT Donnie L. Everette Address 5509 1st N.W. Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 771 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
b) Gunshot wound, right temple, with intracranial hemorrhage, self-inflicted.					
c) Deceased shot self in head					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Deceased shot self in head					
20c. TIME OF INJURY Month Day Year 10 10 5-7 1966					
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work					
20e. PLACE OF INJURY (Home, farm, factory/street, office building, etc.) Home (City or town) Silver Spring (County) Montgomery (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Leap					
EXAMINER'S NAME (Type) BELDEN R. LEAP, M.D.					
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Camden, Arkansas					
22. DATE SIGNED May 7, 1966					
23a. BURIAL Cremation REMOVAL (Specify) TRANSIT	23b. DATE THEREOF May 10, 1966	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Camden, Arkansas	
24. FUNERAL DIRECTOR Robert L. Snowden	24b. ADDRESS 246 N. Washington St. Rockville, Md.	25a. REC'D BY REGISTRAR MAY 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-tranit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						07139						
1. PLACE OF DEATH a. COUNTY Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN lb 32 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital						d. STREET ADDRESS Box 135, Route #2						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)		First "W"	Middle "P"	Last GUNTER	4. DATE OF DEATH May 6 1966	Month May	Day 6	Year 1966				
S SEX Female	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. DATE OF BIRTH December 6, 1916	9. AGE (In years last birthday) 49	10. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS Days 0	10. IF UNDER 24 HRS Hours 0	10. IF UNDER 24 HRS Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy (Retired)			10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.			11. BIRTHPLACE (County & State, or foreign country) Enterprise, Alabama			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Carl Gunter			14. MOTHER'S MAIDEN NAME Tura Thompson									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1939-1959			16. SOCIAL SECURITY NO 427 185 807			17. INFORMANT Mrs. Lillian Gunter, Box 135, Route 2/			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington (County) Virginia (State)					
21. I certify that (X) (this hospital) attended the deceased from April 13, 1966 , to May 6, 1966 , that (X) (we) lost saw the deceased alive on May 6, 1966 , and that death occurred at 230A M , from causes and on the date stated above												
22a. SIGNATURE G. T. Strickland, Jr.			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED May 6, 1966						
22c. PHYSICIAN'S NAME (Type) G. T. Strickland, Jr. M. D.			22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/1966		23c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cem.			23d. LOCATION (City or Town) (County) (State) Arlington, Virginia					
24. FUNERAL DIRECTOR Robinson Funeral Home, Leonardtown, Maryland		ADDRESS						25a. REC'D BY REGISTRAR DATE MAY 10 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

C7143

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7140

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>Suburban Hospital</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>R#1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <i>Charles</i>	Middle <i>Earl</i>	Last <i>Hahn</i>
4 DATE OF DEATH	Month <i>May</i>	Day <i>14</i>	Year <i>1966</i>
5 SEX <i>Male</i>	6 COLOR OR RACE <i>white</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8 DATE OF BIRTH <i>4/15/06</i>	9 AGE (In years at birthday) <i>60 yrs</i>	F UNDER 1 YEAR Months <i>0</i>	F UNDER 24 HRS Days <i>0</i>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick, Maryland USA</i>	
13. FATHER'S NAME <i>Charles Samuel Hahn</i>		14. MOTHER'S MAIDEN NAME <i>Evelyn Zeigler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ce) <i>No</i>		16. SOCIAL SECURITY NO <i>214-10-5410</i>	
17. INFORMANT <i>Rebecca Evelyn Hahn (wife)</i>		Address <i>Add. same.</i>	
18. CAUSE OF DEATH (Enter one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage Massive.</i> DUE TO <i>4221</i> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause <i>Cardio-Vascular Disease -</i> (b) <i>Cerebral Arteriosclerosis -</i> DUE TO <i>lost</i> (c) <i>Cardio-Vascular Disease -</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> .	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>John G. Ball</i>
20f. (City or town) <i>Montgomery</i>		(County) <i>Montgomery</i>	
(State) <i>Md</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <i>5/14/66</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <i>Dr. Charles G. Gathern, Gaithersburg, Md.</i>		Address (Street, city, town, or county) <i>Montgomery County, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-17-66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Mount Calvary Cemetery, Gaithersburg, Md.</i>
24. FUNERAL DIRECTOR <i>Dr. Charles G. Gathern, Gaithersburg, Md.</i>		25a. REC'D BY REGISTRAR <i>DA</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
ADDRESS <i>Dr. Charles G. Gathern, Gaithersburg, Md.</i>		DATE <i>MAY 17 1966</i>	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07141

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Montgomery Maryland		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Bethesda	48 mins.	Laytonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
Suburban		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Edward	I	ce	Hahn
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 22, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Nurseryman		Owner Greenhouse	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Albert George Hahn		Linda Esch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
no		578-18-9302	Gertrud Hahn/ same as above.
Address		INTERVAL BETWEEN ONSET AND DEATH	
		3 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction			
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		OUE TO (b) Coronary Arteriosclerosis	
		OUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i> EXAMINER'S NAME (Type) JOHN G. BALL		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22. DATE SIGNED 5/27/66
Address (Street, city, town, or county) Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-30-66	23c. NAME OF CEMETERY OR CREMATORIUM Herman Church Cemetery Bethesda, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS Bethesda, Maryland	25a. REC'D BY REGISTRAR MAY 31 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

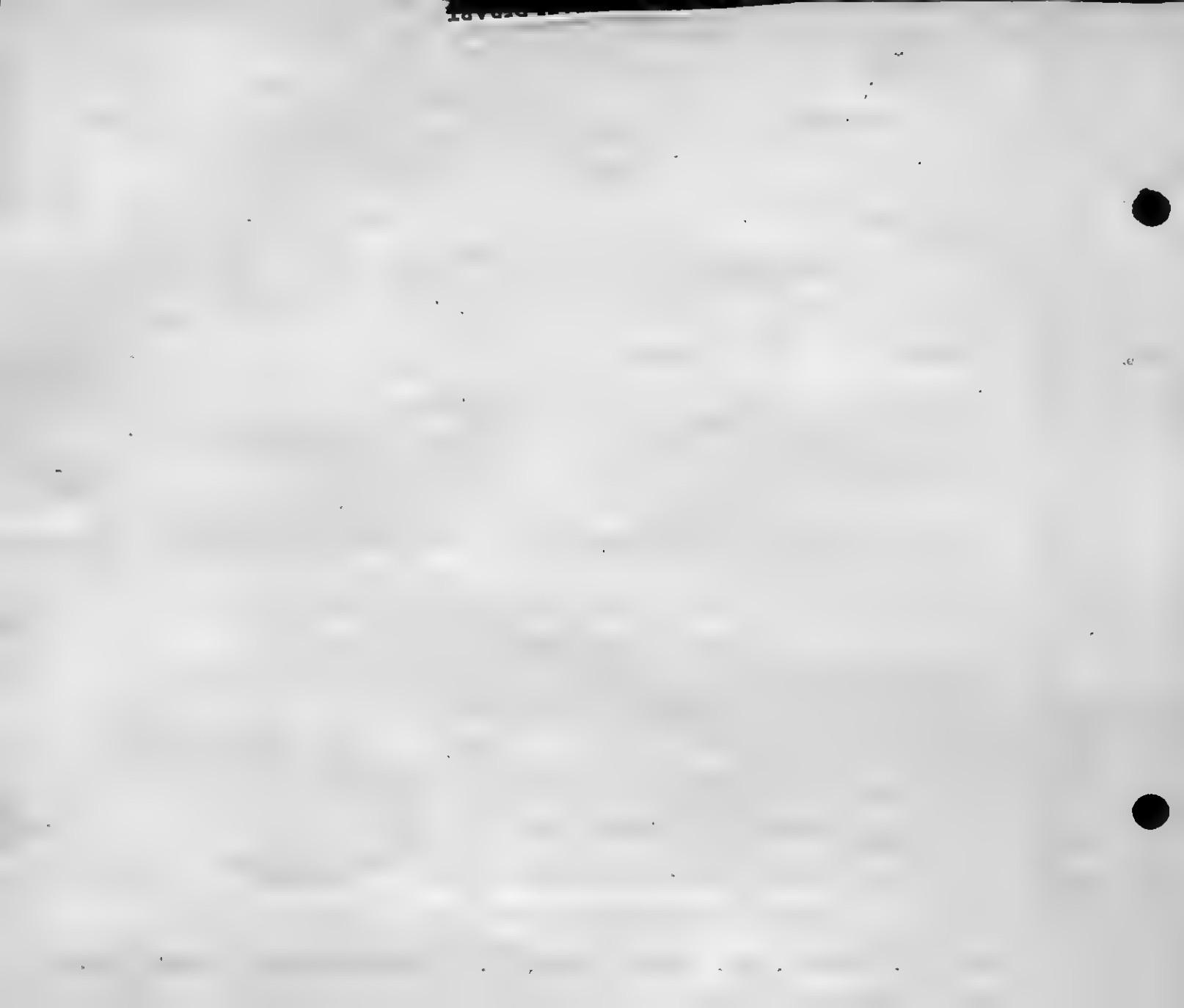
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
C2150						07142								
1. PLACE OF DEATH a. COUNTY			Montgomery			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN lb			e. STATE Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			Kensington			10 years			b. COUNTY Montgomery					
3. NAME OF DECEASED (Type or print)			3419 Plyers Mill Rd.			4. DATE OF DEATH			d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)			First Middle			Last Month			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX			Beda Charlotte			Halberg			5. COLOR OR RACE					
Female			White			XXXXXX			6. COLOR OR RACE					
WIDOWED <input checked="" type="checkbox"/>			Divorced <input type="checkbox"/>			Jan 8, 1880			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			8. DATE OF BIRTH					
Housewife			Own Home			Sweden			9. AGE (In years last birthday)					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME			10. INFORMANT					
Unknown						Unknown			Esther Arms					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)			16. SOCIAL SECURITY NO.			Address			12. CITIZEN OF WHAT COUNTRY?					
No None			None			3419 Plyers Mill Rd. Kensington, Md.			U. S. A.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						Coronary Thrombosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO			Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 day					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)						(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						20c. TIME OF INJURY Month, Day, Year Hour e.m. 20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
20c. TIME OF INJURY Month, Day, Year Hour e.m. 20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that (I) (This Hospital) attended the deceased from <u>Jan 8, 1966</u> to <u>May 24, 1966</u> that (I) (we) last saw the deceased alive on <u>May 24, 1966</u> and that death occurred at <u>8 AM</u> , from the cause and on the date stated above.					
22a. SIGNATOR <u>John J. Curry</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED 5/24/66					
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry</u>			22d. ADDRESS <u>10620 Georgia Ave. S.E. Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>26 May 1966</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Vinehill Cemetery</u>			23d. LOCATION (City, town or county) <u>Plymouth, Mass.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Curran</u>			ADDRESS <u>8434 Georgia Avenue</u>			25a. REC'D BY REGISTRAR <u>MAY 26 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
Warner E. Pumphrey, Inc.			Silver Spring, Md.											



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07143

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		b. COUNTY <i>Maryland</i>	
c. LENGTH OF STAY IN lb <i>23 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>4704 W. FRANKFORT DR.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>ARLETTA</i>	Middle <i>G</i>	Last <i>HALLOCK</i>
4. DATE OF DEATH	Month <i>MAY</i>	Day <i>25</i>	Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>7-9-11</i>	9. AGE (In years last birthday) <i>54 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>
10a. USUA. OCCUPAT. ON (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (County & State or foreign country) <i>Lingston, Tenn</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Minet Gray</i>	14. MOTHER'S MAIDEN NAME <i>FANNY Clark</i>	Address <i>Ab. ne</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>199-12-3487</i>	17. INFORMANT <i>Husband</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>GENERALIZED METASTASIS</i> DUE TO <i>OBSTRUCTIVE JAUNDICE</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 MONTH</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>CHOLANGIOCARCINOMA</i> DUE TO <i>3 MONTHS</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <i>Shavertown, Pa.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>JAN 12, 1966</i> , to <i>MAY 25, 1966</i> , that (I) (we) last saw the deceased alive on <i>MAY 24, 1966</i> , and that death occurred at <i>110A M.</i> from causes and on the date stated above			
22a. SIGNATURE <i>William Frank</i>	22b. DATE SIGNED <i>MAY 25, 1966</i>		
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM FRANK, M.D.</i>	M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>11125 Rockville Pike, Rockville</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/28/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Evergreen Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Shavertown, Pa.</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home Rockville, Md.</i>	25a. ADDRESS <i>11125 Rock Pike</i>	25b. REC'D BY REGISTRAR <i>MAY 26 1966</i>	25b. REGISTRAR'S SIGNATURE <i>George J. Frank</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1
M

67152

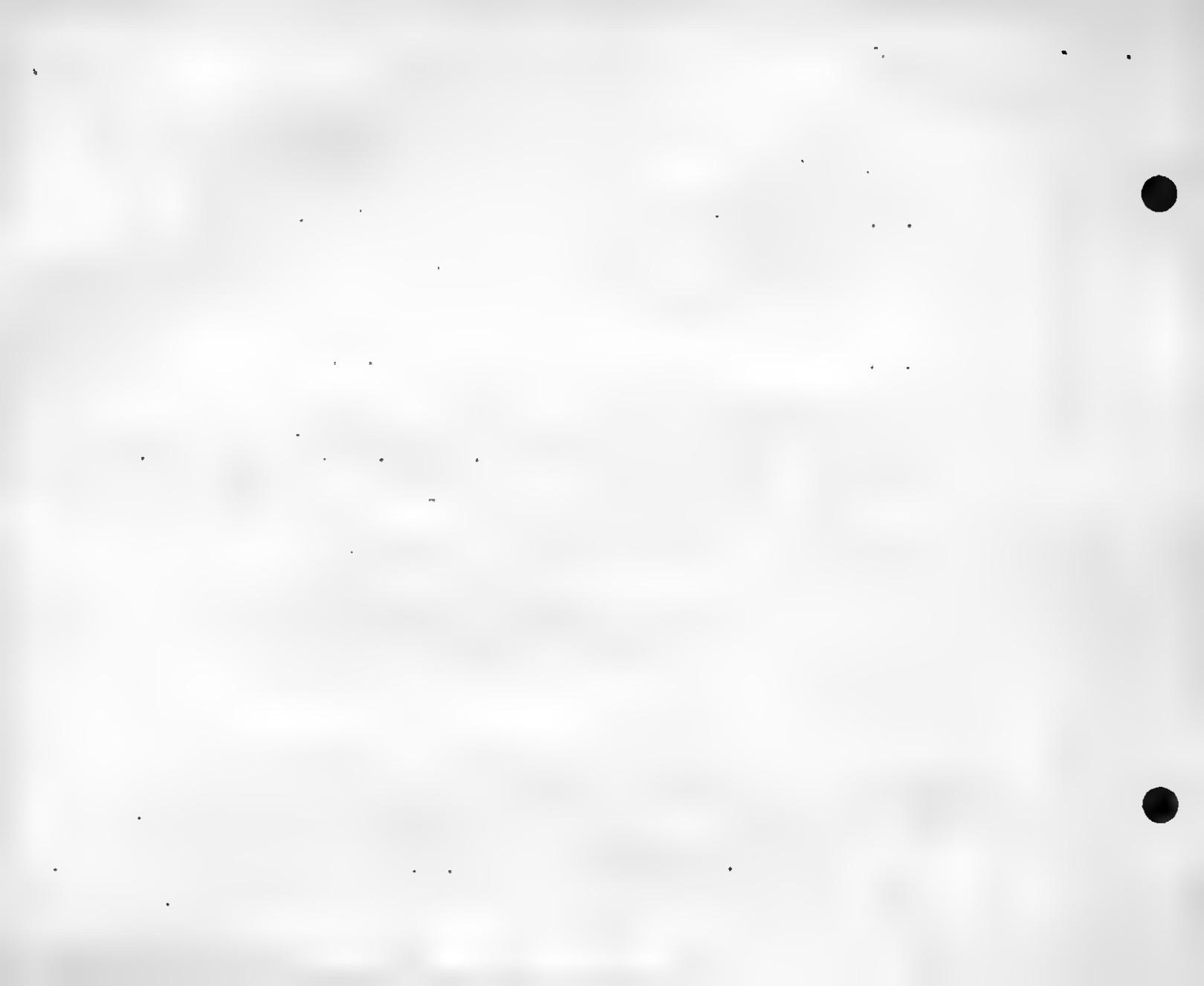
CERTIFICATE OF DEATH

67144

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~the~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Montgomery		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a STATE Maryland		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN 1b 4 days	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d STREET ADDRESS #1 Judi Drive Box 25	e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First Adolph	Middle August	Last HAPPET	
3 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	
8a U.S. AL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		8b. DATE OF BIRTH July 21, 1925		
8c KIND OF BUSINESS OR INDUSTRY RETIRED		8d. AGE (In years last birthday) 40 yrs.		
8e. BIRTHPLACE (County & State, or foreign country) Bronx, N. Y.		8f. IF UNDER 1 YEAR Months 19 Days 66		
8g. COUNTRY OF WHAT USA		8h. IF UNDER 24 HRS. Hours 19 Min. 66		
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO 096-16-4760		
17. INFORMANT Bryans Rd.		Address Maryland		
		Mrs. Pola R. Happel, #1 Judi Dr. Box 25/		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive heart failure DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (If this hospital) attended the deceased from May 17, 1966 , to May 21, 1966 , that (If we) last saw the deceased alive on May 21, 1966 and that death occurred at 800PM , from causes and on the date stated above.				
22a. SIGNATURE <i>Robert L. Piscatelli</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 23 May 1966	
22c. PHYSICIAN'S NAME (Type) Robert L. Piscatelli		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 23, 1966	23c. NAME OF CEMETERY OR CREMATORIY Trinity Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Waldorf, Maryland
24. FUNERAL DIRECTOR Hunt's Funeral Home, Waldorf, Maryland		ADDRESS	25a. REC'D BY REGISTRAR MAY 27 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1 M
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7155

CERTIFICATE OF DEATH

07145

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

SILVER SPRING

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Holy Cross Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

11-17-1913

Sept 15, 1915

50

9. AGE (In years
last birthday)

50

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

ROUMANIA

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Morris

14. MOTHER'S MAIDEN NAME

SAIDIE KRUPNICK

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

YES

WW II

16. SOCIAL SECURITY NO.

577-05-8933

17. INFORMANT

PAUL S. HARAB 2916 Tenare Dr. Chelvah

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4201

Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

DUE TO

17 acute Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH
24 hrs.

Coronary Heart Disease

A.S.H.D.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES ND 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1954, 19 to 5-22, 1960, that (I) (we) last saw the deceased alive on 5-22, 1960, and that death occurred at 12 PM, from the causes and on the date stated above.

22a. SIGNATURE

22b. DATE SIGNED
Bernard Katzen 5-22-60

22c. PHYSICIAN'S NAME (Type)

BERNARD KATZEN M.D. 26 YRS - N.Y.C. R.N.S.C.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF May 24, 1966 Arlington National Cemetery

23c. NAME OF CEMETERY OR Crematory

23d. LOCATION (City, town or county) (State)
Arlington, Va.

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

B. Danzansky & Sons Washington, DC

MAY 26 1966 Charles Judge



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7156

CERTIFICATE OF DEATH

07146

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 4506 Furman Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SANATORIUM & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERTRUDE		First	Middle
4. DATE OF DEATH MAY 13 1966		Last	Month Day Year
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-3-80
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) England.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles B. Ewing		14. MOTHER'S MAIDEN NAME Harriet Cheney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. 1221			
DUE TO (b) Arteriosclerotic Cardiovascular Disease			
DUE TO (c) Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 11, 1966 , to May 13, 1966 , that (I) (we) last saw the deceased alive on May 12 1966 , and that death occurred at 9:20 AM , from the causes and on the date stated above.			
22a. SIGNATURE Gene U. Cohen MD		22b. DATE SIGNED May 13 76	
22c. PHYSICIAN'S NAME (Type) GENE U. COHEN		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 18, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery
24. FUNERAL DIRECTOR Arthur Walters, 254 Carroll NW 4C		ADDRESS J Arthur Walters, 254 Carroll NW 4C	25a. REC'D BY REGISTRAR DATE MAY 17 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



**MARYLAND STATE DEPARTMENT OF HEALTH
RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
S7155		MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)							
<i>Montgomery</i>		<i>Virginia Fairfax</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. STATE b. COUNTY							
<i>Rural</i>		<i>Narrows</i>							
c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (if outside corporate limits, write RURAL and g.v.e nearest town)							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<i>DICKERSON</i>									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
<i>MARK RODNEY HAVENS</i>					<i>May</i>	<i>8</i>	<i>1966</i>		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years) IF UNDER 1 YEAR, IF UNDER 24 HRS last birthday				
<i>Male</i>		<i>White</i>	<i>WIOOWEO</i> <input type="checkbox"/>	<i>3-30-45</i>	21	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
<i>Linenman</i>		<i>R.B. UTIL. (Elec.)</i>		<i>Virginia</i>				<i>U. S.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
<i>Mark A. Havens</i>		<i>Myrtle Ferguson</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
<i>No</i>		<i>280-56-8658</i>		<i>Hospital Records</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>INJURIES Multiple, SEVERE</i> INTERVAL BETWEEN ONSET AND DEATH Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>FALL From ELECTRICAL TOWER(100ft)</i> <i>instant</i>									
OUE TO (b) OUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Deceased fell from electrical tower 100 ft. high.</i>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>7:20 a.m. 5/8 1966</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Field</i>		20f. (City or town) <i>Dickerson Montg. Md.</i>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and In my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Belden R. Reap M.D.</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) <i>Reheaton</i> DATE SIGNED <i>May 8, 1966</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county)		(State)	
<i>Burial-transit 5-8-66</i>				<i>Cedar Grove Cemetery</i>		<i>Narrows, Virginia</i>			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<i>ROBERT A. PUMPHREY Bethesda, Maryland</i>				<i>MAY 10 1966</i>		<i>Charles Judge</i>			



FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
C715S			7148										
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
Montgomery		b. STATE Washington, D.C.											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
R. Crofton		40 hr		Washington, D.C.									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS										e. IS RESIDENCE ON A FARM?	
Wide Water C.R. Canal		G217 30th St. N.W.										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
James		David		Hawkins	MAY	18	1966						
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?					
M.		N.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/27/1944	21 yrs.	Industry	Washington	U.S.A.					
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)											
Bakers Helper		12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Kenith McHawkins		Dorothy McRever											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No		—		Father		Same as #2 above							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA -													
18		DUE TO (b)	INTERVAL BETWEEN ONSET AND DEATH										
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		Drowning	5 min.										
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour p.m. 5/18 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and In my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
EXAMINER'S NAME (Type)		22. DATE SIGNED 5/20/66											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)					
Burial		5/23/66		Mt. Olivet Cem.		WASHINGTON, D.C.							
24. FUNERAL DIRECTOR		ADDRESS		25e. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Jos. Gowler's Sons, Inc.		WASH. D.C.		MAY 25 1966		jCharles Judge							



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07157 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07169

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>	b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>D.O.T</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>		d. STREET ADDRESS <i>208 Cedar Ave</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>LARRY</i>	Middle	Last <i>HAYES</i>	Month <i>MAY</i>	Day <i>18</i> Year <i>1966</i>
4. DATE OF DEATH			5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland.</i>	12. CITIZEN OF WHAT COUNTRY? <i>US</i>
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13. FATHER'S NAME <i>James Hayes.</i>	14. MOTHER'S MAIDEN NAME <i>Frances Monroe</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>Address</i>	17. INFORMANT <i>Father Item #2</i>

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia -</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>
471X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>7936 Old Georgetown Road Bethesda, Maryland</i>	20f. (City or town) (County) (State)

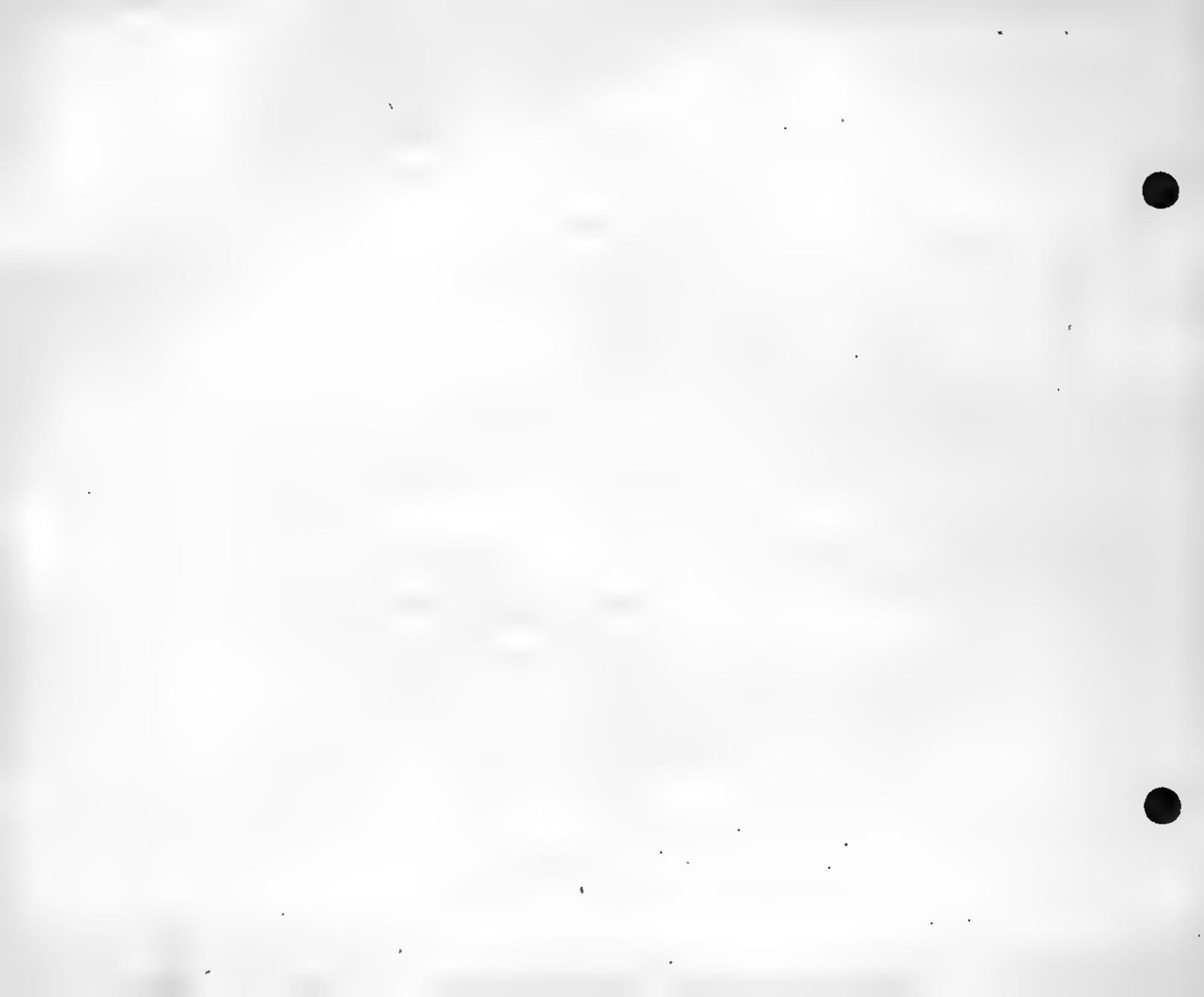
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and In my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
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ACTUAL SIGNATURE <i>John G. Ball</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <i>5/18/66</i>
EXAMINER'S NAME (Type) <i>John G. Ball</i>	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) <i>7936 Old Georgetown Road Bethesda, Maryland</i>		

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/21/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Forest Oak</i>	23d. LOCATION (City, town or county) (State) <i>Gaithersburg Md.</i>
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home Rockville, Md.</i>	ADDRESS <i>1331 Rockville Pike</i>	25a. REC'D BY REGISTRAR <i>MAY 23 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of Statistical Research and Records, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

37158

CERTIFICATE OF DEATH

07150

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban.		d. STREET ADDRESS 5053 Bradley Blvd.	
3. NAME OF DECEASED (Type or print) JAMES E HEFFERMAN		First JAMES	Middle E
4. SEX M	5. COLOR OR RACE W	6. MARRIED WIDOWED <input checked="" type="checkbox"/>	7. NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7-4-86		9. AGE (In years lost b'day) 79 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Hospital Records	
11. BIRTHPLACE (Country & State, or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 083-14-9213A	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pulmonary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO Pharyngeal Obstruction			
(c) DUE TO CARCINOMA of the Tongue			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4420		20f. (City or town) (County) (State) Rockville	
21. I certify that (I) (this hospital) attended the deceased from 4/20 , 19 66 , to 5/5 , 19 66 that (I) (we) last saw the deceased alive on 4/25 19 66 and that death occurred at 60 M, from causes and on the date stated above.			
22a. SIGNATURE Robert A. Barnett		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) ROBERT A. BARNETT M.D.		22d. ADDRESS 809 Viers Mill Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/66	
23c. NAME OF CEMETERY OR CREMATORIAL Potterfield		23d. LOCATION (City or Town) (County) (State) Rockville, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler		ADDRESS 1331 Rockville Pike Rockville, Md.	
25a. REC'D BY REGISTRAR MAY 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15 (4) 20 M 1/66		Bp	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		b. STATE Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 5 miles		b. COUNTY Mont.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Kensington Gardens		d. STREET ADDRESS 13604 Aqua Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Ada	Middle W.	Last Herbelt	DATE OF DEATH MAY 7 1966	Month May	Day 7	Year 1966
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 28 1880 85 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Penn		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Bensted		14. MOTHER'S MAIDEN NAME NW AVAILABLE						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. MARY H. Houck.		Address 13604 Aqua Lane Rockville MD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 12 hr.						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary thrombosis						
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c) Coronary arteriosclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Essential hypertension						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that (I) (this hospital) attended the deceased from 1-9, 1966, to 5-7, 1966, that (I) (we) last saw the deceased alive on 5-3 1966, and that death occurred at 5 PM, from the causes and on the date stated above.								
22a. SIGNATURE Dr. Bury / S. N. Jones		22b. DATE SIGNED 5-7-66						
22c. PHYSICIAN'S NAME (Type) S. N. Jones		22d. ADDRESS 809 Veirs Mill Rd Rockville						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF MAY 10-1966		23c. NAME OF CEMETERY OR CREMATORIAL HARLEIGH CEMETERY		23d. LOCATION (City, town or county) Collingswood, New Jersey (State)		
24. FUNERAL DIRECTOR Barber Akters Washington DC 20010		ADDRESS 274 Carroll St. N.W.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE		
				DATE MAY 10 1966				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07150

CERTIFICATE OF DEATH

Reg. Dist. No.

07152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. It may be retained by the hospital or attending physician after this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>KENSINGTON</i>		c. LENGTH OF STAY IN 1b <i>10516 St. Paul Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10516 St. Paul Street</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>	
3. NAME OF DECEASED (Type or print) <i>WILLIAM HESS</i>		First <i>(NONE)</i>	Middle <i></i>
4. DATE OF DEATH <i>May 8 1966</i>		Last <i>HESS</i>	Month <i>May</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>CAUCASIAN</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Mar. 9, 1884</i>		9. AGE (In years lost birthday) yrs. <i>82</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MERCHANT (ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dry Goods</i>	
10c. BIRTHPLACE (State or foreign country) <i>Germany</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>HEINRICH HESS</i>		14. MOTHER'S MAIDEN NAME <i>ROSA LEVY</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>338-12-4654</i>	
17. INFORMANT <i>Robert T. Thibadeau</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>33IX</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Central Hemorrhages</i> <i>Arterio sclerosis - generalized</i>	
		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Apr. 29, 1966</i> to <i>May 8, 1966</i> that I last saw the deceased alive on <i>May 2, 1966</i> and that death occurred at <i>3720 Farragut Avenue</i> ADDRESS (Street, city or town, state) <i>Kensington, Md. 20795</i>		DATE SIGNED <i>May 8, 1966</i>	
ACTUAL SIGNATURE <i>Robert T. Thibadeau</i>		PHYSICIAN'S NAME (Type) <i>Robert T. Thibadeau</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>5-9-66</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>GEO. WASH. Cem.</i>		22d. LOCATION (City, town, or county) <i>HATTSVILLE MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gedberg Funeral Home 4217 90th St. NW</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 10 1966</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

27153

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if instit. or residence before admission) b. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. STREET ADDRESS <i>3512 Nimitz Rd.</i>	
3 NAME OF DECEASED (Type or print) <i>Arnold</i>		f. DATE OF DEATH Month Day Year <i>5 - 24 1966</i>	
S. SEX <i>m.</i>	6. COLOR OR RACE <i>WV</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>12-28-09</i>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Supervisor</i>		10b KIND OF BUSINESS OR INDUSTRY <i>D.C. Transit</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>	
13. FATHER'S NAME <i>Raymond Hodgson</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>1943-1945</i>		16. SOCIAL SECURITY NO. <i>139-03-8419</i>	
17. INFORMANT <i>Ruth - wife - same</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchogenic carcinoma, left lung with widespread metastasis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause lost. (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>1-1/2 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <i>1963</i> to <i>5-24</i> , 1966, that (I) (we) last saw the deceased alive on <i>5-24</i> 1966, and that death occurred at <i>7:25 A.M.</i> from causes and on the date stated above		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>Morris Perry</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>5-24-66</i>
22c. PHYSICIAN'S NAME (Type) <i>Morris Perry</i>		22d. ADDRESS <i>11602 Georgia Ave., Silver Spring, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/27/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>
24. FUNERAL DIRECTOR <i>TYSON WHEELER</i>		25a. ADDRESS <i>1321 Rockville Pike Rockville, Maryland</i>	25b. REC'D BY REGISTRAR <i>MAY 26 1966</i>
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



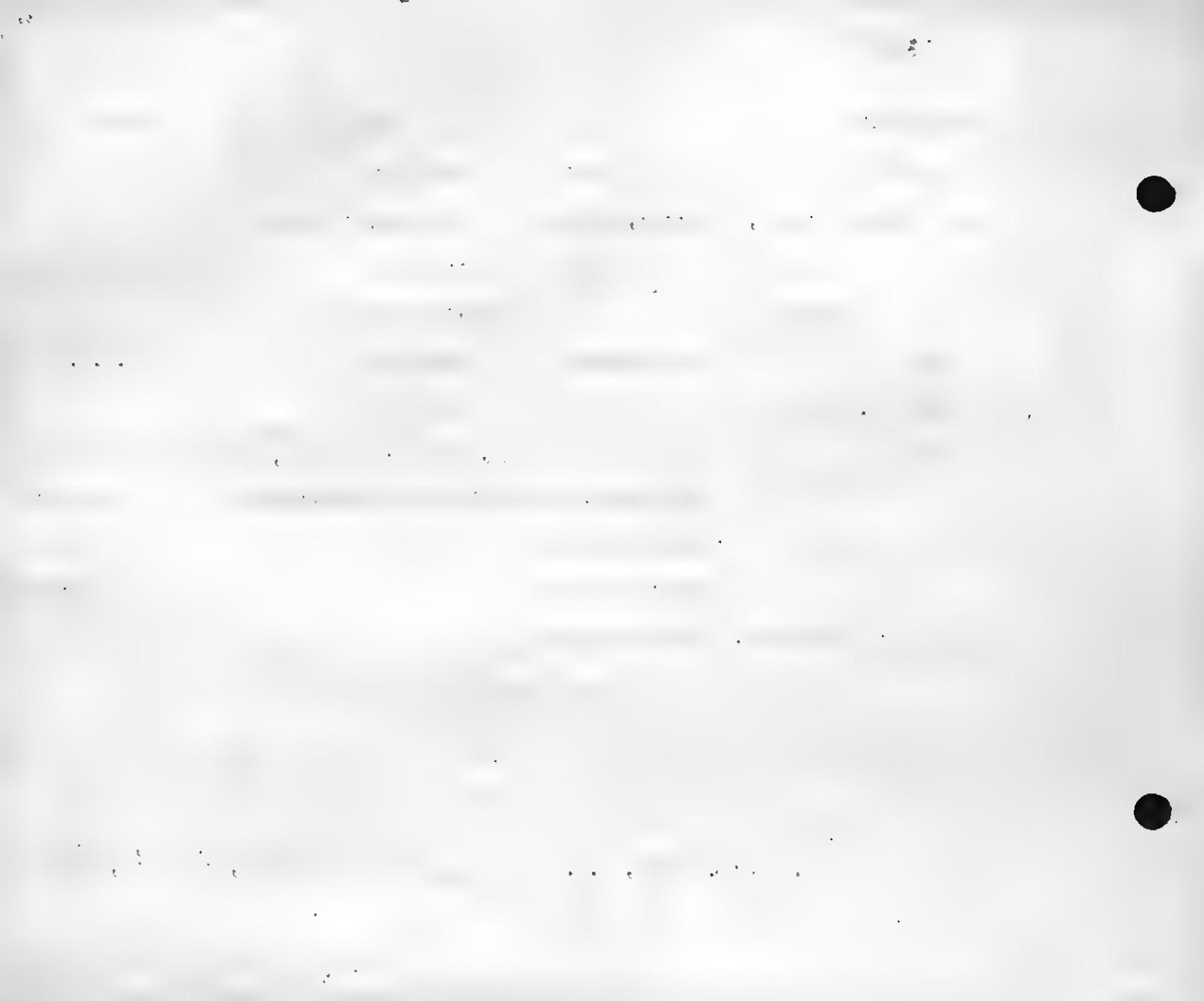
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Harford	
c. LENGTH OF STAY IN lb 37 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS Southampton Farm	
3. NAME OF DECEASED (Type or print) John Brian Holden		4. DATE OF DEATH Month Day Year May 5 1966	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED		8. DATE OF BIRTH 14 July 1945	
9. AGE (in years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 0 Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gwynne L. Holden		14. MOTHER'S MAIDEN NAME Jean Todd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Records Address The Clinical Center, Bethesda, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral and spinal cord hemorrhage 201X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombocytopenia DUE TO (c) Hodgkins disease DUE TO	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH 42 hours			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21. I certify that I (this hospital) attended the deceased from 29 March, 1966 , to 5 May, 1966 , that I (we) last saw the deceased alive on 5 May, 1966 , and that death occurred at 3:45 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE H. Thomas Foley, M.D.			
22b. DATE SIGNED 6 May 1966			
22c. PHYSICIAN'S NAME (Type) H. Thomas Foley, M.D.			
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-7-66	
23c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion Cemetery		23d. LOCATION (City, town or county) (State) Bel Air, Md.	
24. FUNERAL DIRECTOR Lee Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE MAY 10 1966	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page II
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page III
 Page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07155

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE D.C.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase Md.		c. LENGTH OF STAY IN lb SINCE APRIL 1, 1966.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HASHINGTOM.		d. STREET ADDRESS 1425 Rhode Island Ave. N.W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7103 - CONNECTICUT AVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ELIZABETH SMITH HOLLAND		First	Middle	Last	4. DATE OF DEATH May 13 1966	Month	Day	Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 4- 1878		9. AGE (In years lost birthday) yrs. 87	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED.		10b. KIND OF BUSINESS OR INDUSTRY US GOVT. Dept of Interior		11. BIRTHPLACE (State or foreign country) ORLEAN VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George L. HOLLAND		14. MOTHER'S MAIDEN NAME JACQUESINA M. PAYNE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No unknown) NO		16. SOCIAL SECURITY NO — — —		17. INFORMANT JAC H. BUSHONG Address NEPHEW - 7103 CONN. AVE. Chevy Chase Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7834 HEART FAILURE -						INTERVAL BETWEEN ONSET AND DEATH 12 hrs.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO — (c) DUE TO —								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —						
20c. TIME OF INJURY Month, Day, Year Hour o.m. — 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) — (State) —
21. I certify that I attended the deceased from 1956 , 19, to 5-13 , 19 66 , that I last saw the deceased alive on May 12 , 19 66 , and that death occurred at 2:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Irene G. Tamagna</i> PHYSICIAN'S NAME (Type) IRENE G. TAMAGNA M.D.								ADDRESS (Street, city or town, state) 5130 Wisconsin Ave., N.W., Washington, D.C.
22c. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-66		22c. NAME OF CEMETERY OR CREMATORIUM Orleans Meth. Church		22d. LOCATION (City, town, or county) Orleans		(State) Va.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Ganters Sons		ADDRESS 5130 Wisconsin Ave., N.W., Washington, D.C.		24a. REC'D BY REGISTRAR MAY 18 1966		24b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C7156 C7156

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		Item 9 Film 677 6/10/66 mm		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>		c. LENGTH OF STAY IN 1b <i>5 days & 5 hours</i>		a. STATE <i>D. C.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>WASHINGTON SANITARIUM & HOSPITAL</i>				b. COUNTY <i>Rural</i>	
3. NAME OF DECEASED (Type or print) <i>Bernice Almira SAUNDERS HOWARD</i>		First <i>Bernice</i>	Middle <i>Almira</i>	Last <i>SAUNDERS HOWARD</i>	4. DATE OF DEATH Month Day Year <i>May 25 1966</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>8-2-18</i>	9. AGE (In years last birthday) <i>46 47 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk - Treas. Dept.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Caterment</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Mass.</i>	
13. FATHER'S NAME <i>ALPHAEUS SAUNDERS</i>		14. MOTHER'S MAIDEN NAME <i>MARY Harvey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <i>No</i>		16. SOCIAL SECURITY ND. <i>Unknown</i>		17. INFORMANT <i>CHOT.</i>	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pleural effusion</i>					
170X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>metastatic carcinoma</i> (c) <i>Carcinoma of breast</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Washington, D.C.</i>	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>March 3, 1966</i> , to <i>May 25, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 25, 1966</i> , and that death occurred at <i>550 M</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>John D. Buswold MD</i>		22b. DATE SIGNED <i>5/26/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>John D. Buswold, MD.</i>		22d. ADDRESS <i>1601 16th St NW DC</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-31-66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Cambridge Cemetery</i>	23d. LOCATION (City, town or county) <i>Cambridge, Massachusetts</i>	(State)
24. FUNERAL DIRECTOR <i>John T. Rhines Company 3015 12th Street, N.E.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>MAY 31 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07157

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>DOA</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>	e. STREET ADDRESS <i>1927 Lyttonsville Road.</i>		
3. NAME OF DECEASED (Type or print) <i>Sauna Elizabeth Hudson</i>	First Last Middle	4. DATE OF DEATH <i>May 28 1966</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-22-19</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>(Washington) Motor Hotel, Parkmeadows, Virginia</i>	11. BIRTHPLACE (State or foreign country) <i>USA</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Edgar Hudson</i>	14. MOTHER'S MAIDEN NAME <i>Jackson, Blanche</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <i>No None</i>	16. SOCIAL SECURITY NO. <i>229-09-2369</i>
17. INBURMENT <i>Geo. P. L. Rongos - 1429 Madison St. NW D.C.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exsanguination - Transection of Thoracic Aorta - Auto. Accident -</i> 8164 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> OUE TO OUE TO (c)	Address <i>Friend</i> INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>driving car made u turn struck by another auto</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>driving car made u turn struck by another auto</i>		
20c. TIME OF INJURY Month, Day, Year Hour <i>11:30 p.m. 5/28 1966</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <i>Highway 280</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) <i>Rhodes Mont. Md.</i>	20f. (City or town) (County) (State) <i>Rhodes Mont. Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED <i>5/30/66</i>
EXAMINER'S NAME (Type) <i>John G. Ball</i>	OEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	Address (Street, city, town, or county) <i>7936 Old Georgetown Rd., Bethesda, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>June 1, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>West End Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Wytheville, Virginia</i>
24. FUNERAL DIRECTOR <i>Allen Carter 8434 Georgia Avenue Warner E. Pumphrey, Inc.</i>	ADDRESS <i>Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR <i>JUN 2 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7156

07158

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
a. COUNTY Montgomery		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 26420 Ridge Rd.		d. STREET ADDRESS 26420 Ridge Rd.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ina Rhea Hughes		4. DATE OF DEATH May 17 1966	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>
8. DATE OF BIRTH March 27, 1892		9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Statistician		10b. KIND OF BUSINESS OR INDUSTRY Missouri	11. BIRTHPLACE (County & State, or foreign country) USA
13. FATHER'S NAME William C. Brown		14. MOTHER'S MAIDEN NAME Ella E. Kendig	
15. WAS DEC EASSED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 580-52-9165	17. INFORMANT Address Walter E. Hughes, 25101 Oak Dr. Damascus, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute congestive Heart Failure		Years	
DUE TO as manifest by (b) Acute congestive Heart Failure		?	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Two previous Myocardial Infarction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 105 Russell Ave., Gaithersburg, Md.
20f. (City or town) 105 Russell Ave., Gaithersburg, Md.		(County) Gaithersburg, Md.	
		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1966 , to May 17, 1966 , that (I) (we) last saw the deceased alive on 2-15 1966 , and that death occurred at X M, from the causes and on the date stated above.		22b. DATE SIGNED 5-19-66	
22a. SIGNATURE Jack Schumacher		22b. DATE SIGNED 5-19-66	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher, MD.		22d. ADDRESS 105 Russell Ave., Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 20, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cedar Hill
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DA	25b. REGISTRAR'S SIGNATURE J Charles Judge
		DATE MAY 23 1966	



1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, after any event, within 72 hours after death.

- Authorized given by County Medical Examiner, Dr. G. Ross

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C7167		37153	
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>10 yrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give Street address) <i>26 Philadelphia Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ellen C. Hurley</i>		First <i>Ellen</i>	Middle <i>C</i>
4. DATE OF DEATH <i>May 29 1966</i>		Last <i>Hurley</i>	Month <i>May</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>May 12 1872</i>		9. AGE (In years last birthday) <i>94 yrs.</i>	10. IF UNDER 1 YEAR Months <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Falmouth, Virginia</i>
13. FATHER'S NAME <i>Austin Cowne</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Mrs. Loretta Hurley</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420</i>		Address <i>26 Philadelphia Ave. Takoma Park, Md.</i>	
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerosis, generalized</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
DUE TO (c)		6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , to <i>May 26, 1966</i> , that (II) (we) last saw the deceased alive on <i>May 26 1966</i> , and that death occurred at <i>1/2 M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>May 29, 1966</i>	
22a. SIGNATURE <i>Allen S. Gardner, M.D.</i>		22b. DATE SIGNED <i>May 29, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Allen S. Gardner</i>		22d. ADDRESS <i>1807 EIDON LANE Silver Spring, Md.</i>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>JUNE 1, 1966.</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet Cem.</i>	23d. LOCATION (City, town or county) (State) <i>WASHINGTON D.C.</i>
24. FUNERAL DIRECTOR <i>Charles J. Walter</i>	ADDRESS <i>254 CARROLL ST NW</i>	25a. REC'D BY REGISTRAR <i>MAY 31 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Walter</i>



M
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07168

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07160

1. PLACE OF DEATH
• COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Brinklow

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MARYLAND

c. LENGTH OF STAY IN lb

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

May

12

1966

5. SEX

Female

6. COLOR OR RACE

Negro

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

3-11-1899

9. AGE (In years
last birthday)

67

F UNDER 1 YEAR

Months

Days

F UNDER 24 HRS.

Hours

Mn.

13. FATHER'S NAME

Charles Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

Address

(Yes, no, or unknown) (If yes give war or dates of service)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4201

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e.)

INTERVAL BETWEEN
ONSET AND DEATH

Acute Coronary Insufficiency
Coronary Artery Heart Disease.

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

2d. INJURY OCCURRED
While Not While
at work at work

2d. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

(County)

(State)

21. I certify that I took charge of the remains described above, Held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, City, Town, or County)

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)
Belen R. Reap
BELDEN R. REAP, M.D.

22c. NAME OF CEMETERY OR CREMATORIUM
Spenc Spring, Cem.

22d. LOCATION (City, town, or county)

Spenc Spring, Ma.

(State)

23. FUNERAL DIRECTOR

ADDRESS
Rockville, Ma.

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

MAY 18 1966

Charles Judge

VR A15ME
5M J/62

your
file

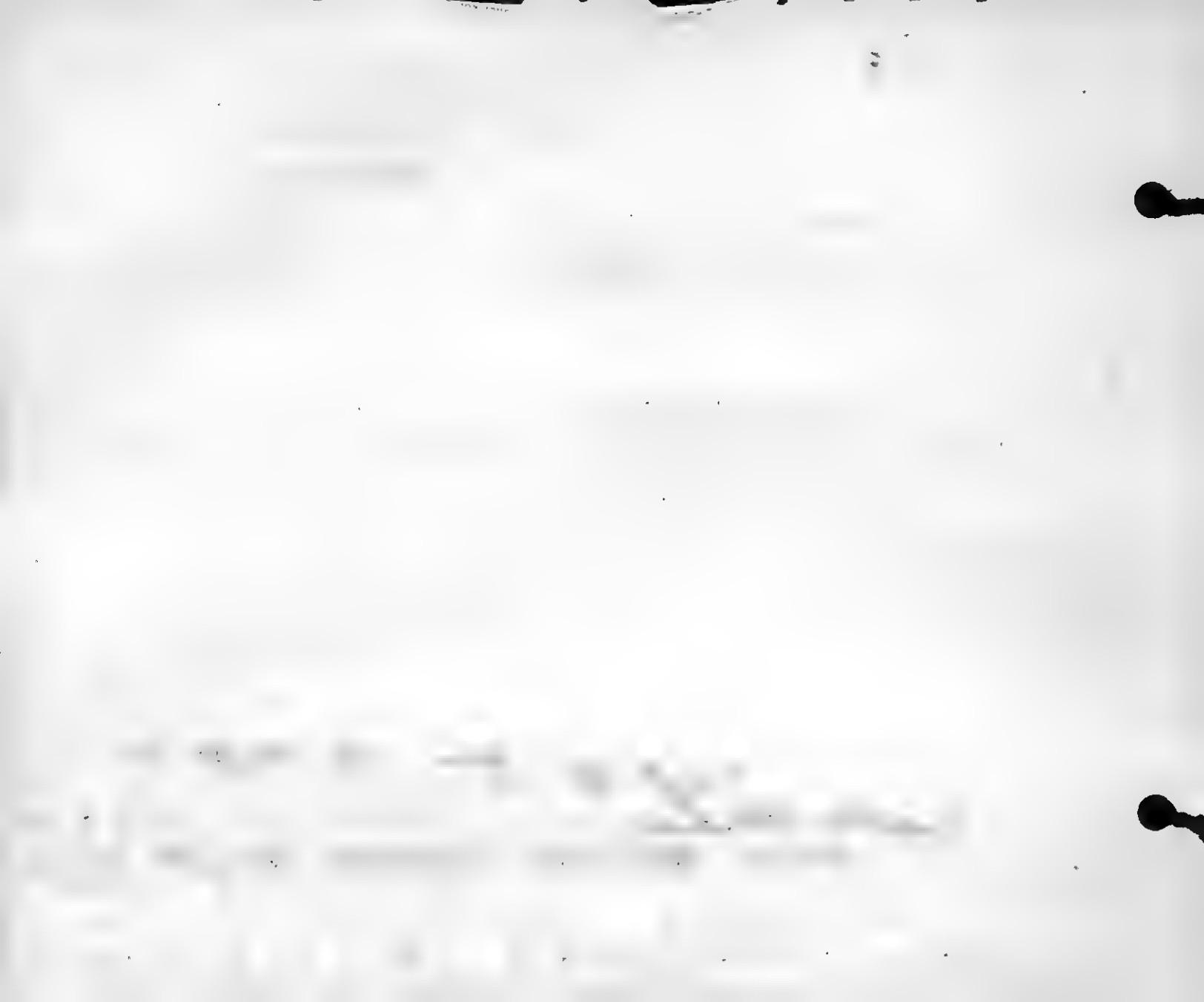


1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE											
Monocacy				Maryland											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1B											
Silver Spring				27 days											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM?											
Holy Cross Hospital or Silver Spring				Adelphi 1 1810 Metzerott Rd											
3. NAME OF DECEASED (Type or print)				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
DAVID Shaffer Jarvis							May	20		1966					
5. SEX				6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
Male				White	<input type="checkbox"/>	<input checked="" type="checkbox"/>	8/14/33	32 yrs.	Months	Days	Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Engineer				IBM				Penns				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME											
David Jarvis III				Eva A. Maria											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.				17. INFORMANT				678 1/ Address Kilnia Drive			
				204-74-7088				David Jarvis III Lake Park, Florida							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Glomerulonephritis												INTERVAL BETWEEN ONSET AND DEATH			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1966, to <u>May 20</u> , 1966, that (I) (we) last saw the deceased alive on <u>May 17</u> 1966, and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.				22b. DATE SIGNED <u>5-20-66</u>											
22a. SIGNATURE <u>Morton Altshuler</u>				ATTENDING M.D. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>9205 New Nancy Ave. Silver Spring, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Society) <u>Burial</u>				23b. DATE THEREOF <u>May 24 1966</u>				23c. NAME OF CEMETERY OR CREMATORIUM <u>Georgie Ave.</u>				23d. LOCATION (City, town or county) <u>Philadelphia, Penna.</u>			
24. FUNERAL DIRECTOR <u>C. Glenister</u> <u>Warren E. Pumphrey, 910 Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>								25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outls de corporate limits, write RURAL and give nearest town)

Kensington

c. LENGTH OF STAY IN lb

1 month

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Carroll Hall Sanitorium

3. NAME OF
DECEASED
(Type or print)

Helen First
Middle
M.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Washington DC

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

2733 Ordway St. n.w.

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE
OF
DEATH

Month
5

Day
17

Year
1966

9. AGE (In years
last birthday)

77
yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Sioux City, Iowa

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Stephen Johnston

Mary Ellen Kennelly

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war/grades of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

561-20-0728A Dorothea M. Jarecki same as #8

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

Congestive heart failure
Arteriosclerotic heart disease

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Pneumonia

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. —
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1 1966 to 5/17/66, that (I) (we) last
saw the deceased alive on 5/17/66 and that death occurred at 11 AM, from the causes and on the date stated above.

22a. SIGNATURE

John B. Chisham

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
5/17/66

22c. PHYSICIAN'S
NAME (Type)

John B. Chisham

22d. ADDRESS

8805 Conn. Ave. N.W. Washington, D.C.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

removal

23b. DATE THEREOF

5/19/66

23c. NAME OF CEMETERY OR CREMATORIAL

Forest Lawn Memorial Park

23d. LOCATION (City, town or county)

Los Angeles, Calif.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

The S.H. Hines Company

ADDRESS

Washington, D.C.

25a. REC'D BY REGISTRAR

MAY 19 1966

25b. REGISTRAR'S SIGNATURE

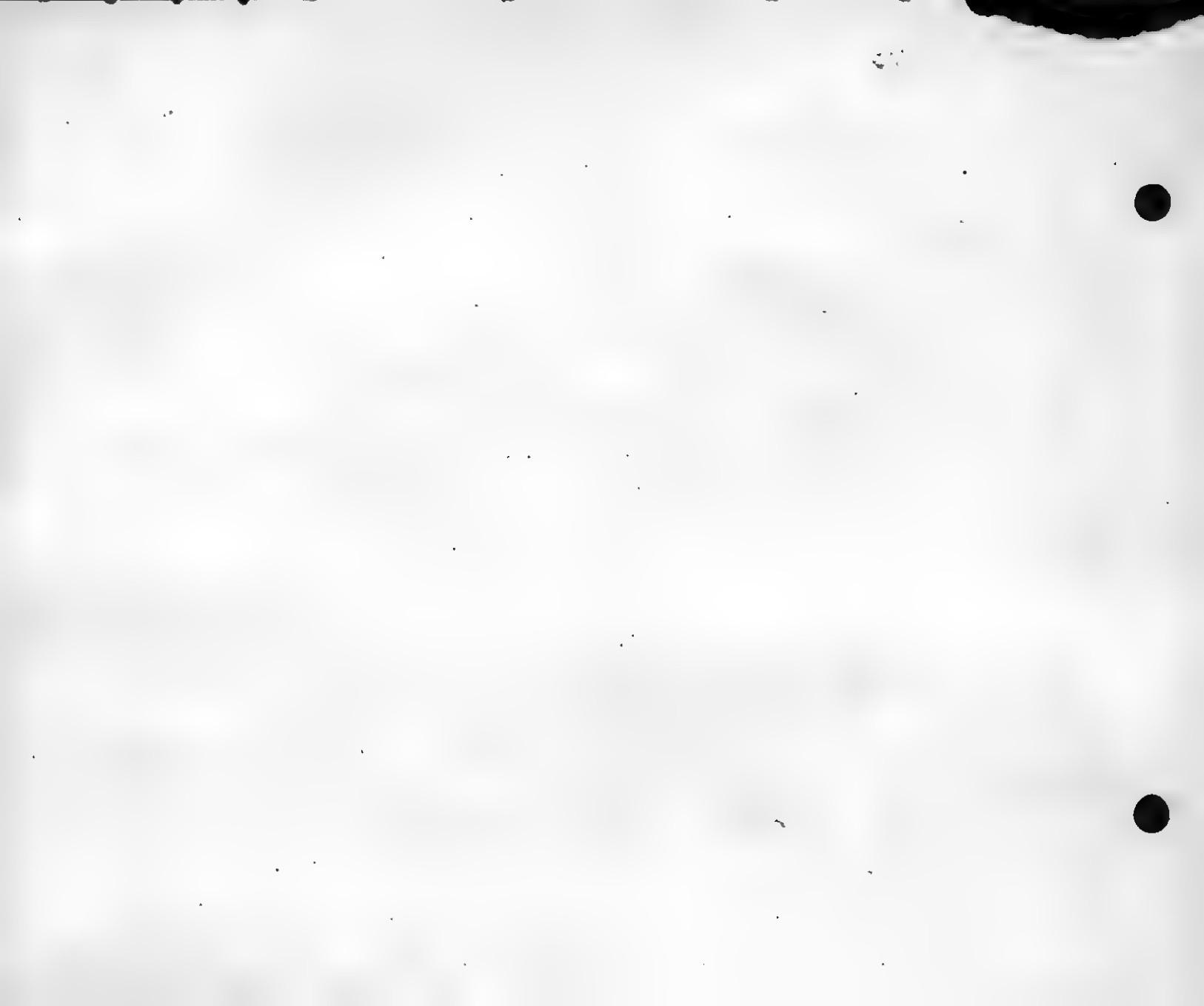
Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE				b. COUNTY						
Montgomery MARYLAND				Maryland				Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 2 weeks 6 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital				d. STREET ADDRESS 328 Highview Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Charles	Middle Elliott	Last Jefferson	4. DATE OF DEATH May 5 1966	Month May	Day 5	Year 1966						
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1893	9. AGE (in years last birthday) 73 yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer				10b. KIND OF BUSINESS OR INDUSTRY Self Employed				11. BIRTHPLACE (County & State, or foreign country) Ohio				12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William Jefferson				14. MOTHER'S MAIDEN NAME Hugenia Eustic										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes				16. SOCIAL SECURITY NO. 313-16-3470				17. INFORMANT Nancy Dykstra 407 Ellsworth Drive Silver Spring, Maryland				Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)	Pulmonary Embolus (from left leg)								INTERVAL BETWEEN ONSET AND DEATH 1 day			
		DUE TO (c)	Cerebral thrombosis								20 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
Accidental fall														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) Arlington	(County) Virginia	(State)
19														
21. I certify that (I) (this hospital) attended the deceased from <u>May 4, 1966</u> , to <u>May 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 4, 1966</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.												22b. DATE SIGNED <u>May 5, 1966</u>		
22a. SIGNATURE <u>Sydney Leventhal</u>												22b. DATE SIGNED <u>May 5, 1966</u>		
22c. PHYSICIAN'S NAME (Type) Sydney Leventhal, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS 9210 Colesville Rd, Silver Spring Md		
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9 May 1966				23c. NAME OF CEMETERY OR CREMATORY Arlington National Cen.				23d. LOCATION (City, town or county) Arlington, Virginia		
24. FUNERAL DIRECTOR John Thomas Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Avenue Silver Spring, Md.				25a. REC'D BY REGISTRAR MAY 9 1966				25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

Items 20&21 Film G378 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7172

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7164

1. PLACE OF DEATH
COUNTRY

Montgomery
Maryland

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

write RURAL and give nearest town)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE
West Virginia

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CHARLESTOWN

d. STREET ADDRESS

RD # 1

e. IS RESIDENCE
ON A FARM?

YES NO

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

DICKERSON

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Month

Day

Year

ROBERT H.

JENKS

May

8 1966

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

10-23-41

9. AGE (In years
at death/birthday)

24 yrs.

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT
COUNTRY U.S.A.

13. FATHER'S NAME

Paul Jenks

14. MOTHER'S MAIDEN NAME

Evelyn Bunts

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

731-32-8109 Paul Jenks, father, same item # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

1/20/53

DUE TO

(b)

DUE TO

(c)

INJURIES Multiple SEVERE

INTERVAL BETWEEN
ONSET & DEATH
INSTANT

Fall from Electrical Tower (100 ft)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Deceased fell from electrical tower when part broke off

20c. TIME OF INJURY Month, Day, Year
Hour a.m.

7:20 2pm. 5/8 19 66

20d. INJURY OCCURRED
at work Not at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

Field Dickerson Mont., Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and In my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

BELDEN R. PKEP MD

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22. DATE SIGNED

May 8, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

5/11/66

23c. NAME OF CEMETERY OR CREMATORIUM

Riverside cemetery

23d. LOCATION (City, town or county)
(State)

Whitney Point, N.Y.

24. FUNERAL DIRECTOR

Tyson Wheeler Funeral Home

1721 Rock Pike

Rockville, Maryland

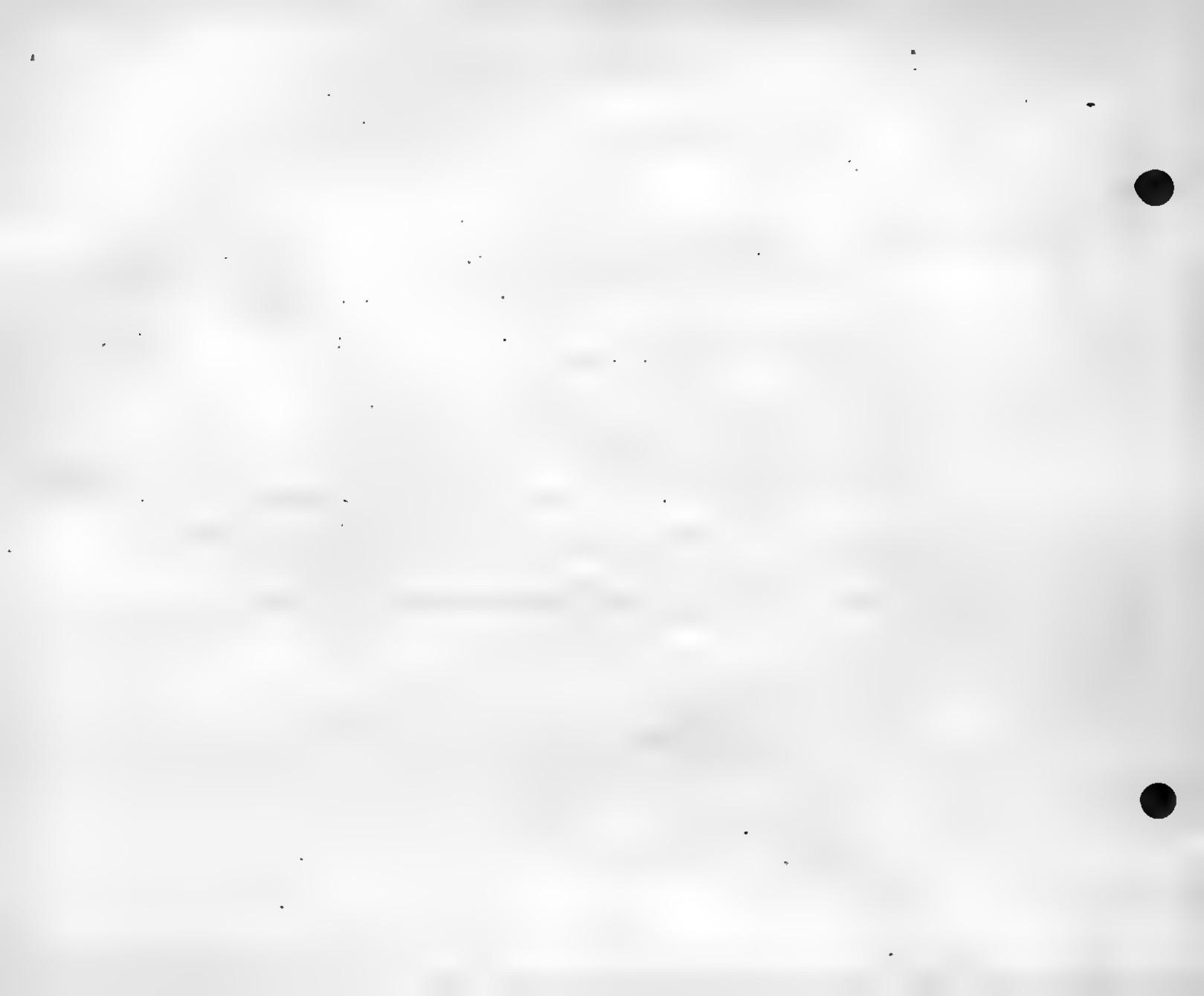
25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE MAY 10 1966 Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1
M
C7173

1
C7166

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)

FAIRLAND

c. NAME OF HOSPITAL OR INSTITUTION (if not in hosp tel, give street address)

2326 FAIRLAND Rd.

3. NAME OF DECEASED

(Type or print)

DOROTHY

First

MARYLAND

d. LENGTH OF STAY IN HOSPITAL

LIFE

5. SEX

FEMALE

6. COLOR OR RACE

W.

7. MARRIED NEVER MARRIED

W DOWED DIVORCED

8. DATE OF BIRTH

10d. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired)

11b. KIND OF BUSINESS OR INDUSTRY

11c. BIRTHPLACE (County & State, or foreign country)

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (e)

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause (e), stating the underlying cause (e),

DUE TO

cause (e),



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)							
				a. STATE	Maryland	b. COUNTY	Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
d. LENGTH OF STAY IN 1b				Rockville							
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		208 Frederick Ave.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?					
				212 Lincoln Avenue		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE DF DEATH	Month	Day	Year			
		Elizabeth G. Johnson			May 21,			1966			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 YEAR	11. UNDER 24 HRS				
F		Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 15, 1907	58 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
Housewife					Maryland			U.S.A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
Andrew Warfield			Ella Dorsey								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
					Ella Holland (Daughter) Item #2						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>										15 min	
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive heart disease</i> (c) <i>Angina Pectoris</i>										15 years 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)							
		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19						1952, 19		to 5/21, 1966			
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE		<i>Ella Holland</i>								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/25/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Lincoln Park	23d. LOCATION (City, town or county) (State) Rockville, Md.
24. FUNERAL DIRECTOR <i>Snowden Fun. Home Rockville, Md.</i>		25a. REC'D BY REGISTRAR DA	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
		MAY 25 1966	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

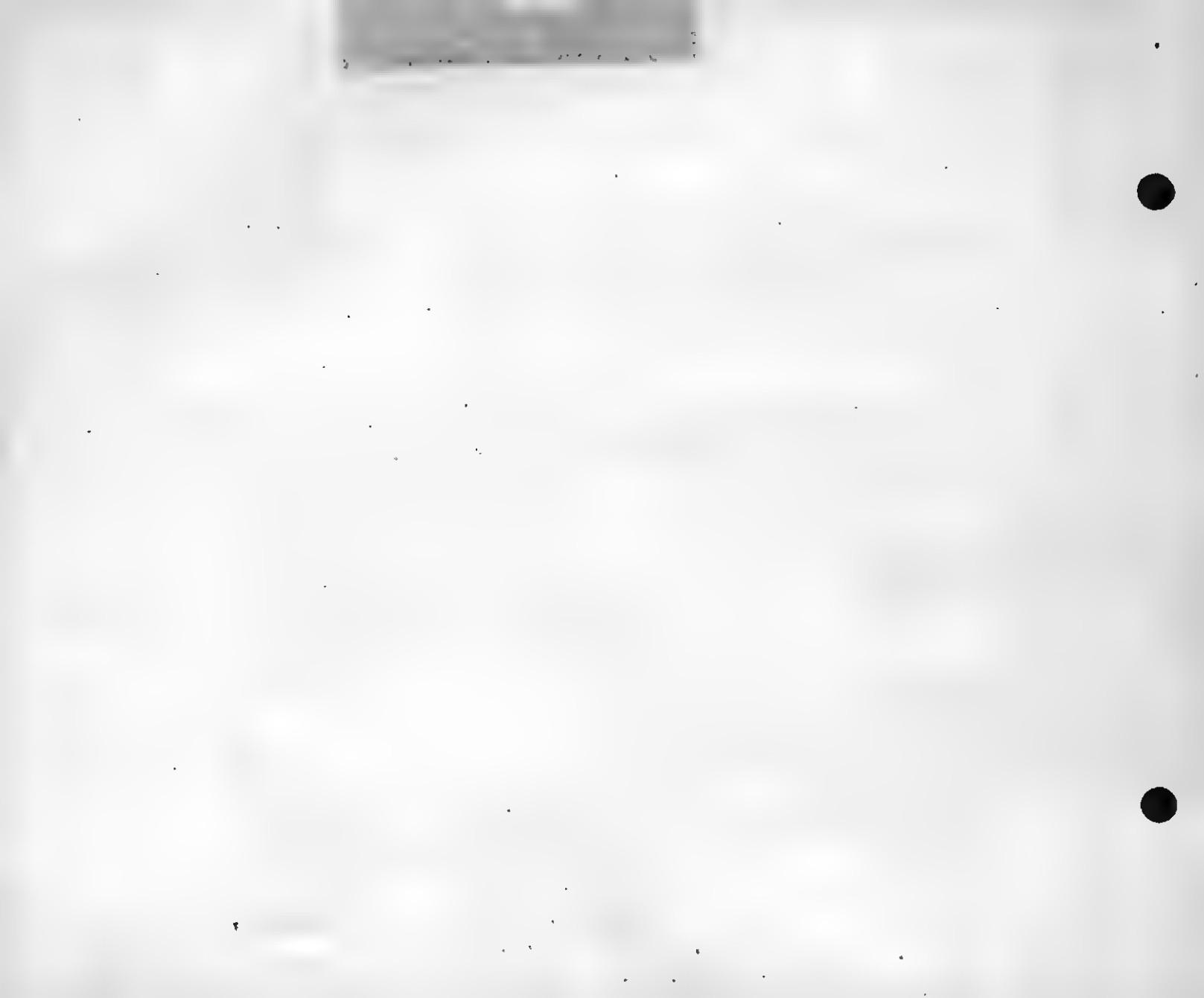
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE											
Montgomery - MARYLAND				Md.											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY											
Bethesda.				Montgomery											
c. LENGTH OF STAY IN MD				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)											
15 1/2 hr				Bethesda.											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS											
Woods-inn Kenwood off Kennedy Dr				5117 Fairglow Lane											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year							
Steven		Francis		Johnston	May	8	1966								
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS								
M.		W.	WIOOWEO <input type="checkbox"/> DIVORCEO <input type="checkbox"/>	9/25/56	9 yrs.	Months	Days	Hours	Min.						
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
								Wash. D.C.				21. S.A.			
13. FATHER'S NAME												14. MOTHER'S MAIDEN NAME			
Francis Rinehart Johnston												Elizabeth R. Johnston			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address			
								Samuel Del Vecchio				Overdale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Asphyxia.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b) Stab-wounds of Larynx + Neck.				DUE TO (c) Sudden.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Stabbed-By-Assailant-See-Crime-											
20c. TIME OF INJURY Month, Day, Year Hour 3:20 p.m. 5/8/66				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, officbldg., etc.) Woods.				20f. (City or town) (County) (State) Bethesda Mont. Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>												22. DATE SIGNED			
ACTUAL SIGNATURE <i>John G. Ball</i>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John G. Ball												M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 5/9/66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/11/66				23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National				23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Inc., Wash., D.C.								23e. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE MAY 12 1966 g. Charles Judge			





1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. STATE									
MONTGOMERY MARYLAND				MARYLAND MONTGOMERY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
BETHESDA (RURAL)				DOA KENSINGTON									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
U.S. Naval Hospital, Bethesda, Md.				5122 White Flint Drive									
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
Eleanor			True	JORDAN		May	3	19	66				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours	12. IF UNDER 24 HRS. Days	13. CITIZEN OF WHAT COUNTRY?				
Female		Cauc.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 19 1905	61 yrs. 0	0	24	0	U.S.A.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)									
Housewife				Newton, Massachusetts									
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME									
John Preston TRUE				Lillian Larcie CRAWFORD									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT (Husband) Address									
No.				Unknown Franklin E. JORDAN/Flint Dr., Kensington									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Calcific aortic valvular stenosis.													
4211 Conditions, if any, which gave rise to immediate causa (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ DUE TO _____ DUE TO _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Belden R. Keap, M.D.</i> EXAMINER'S NAME (Type) <i>Belden R. Keap, M.D.</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>May 3, 1966</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 5-6-66				23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION (City, town or county) Suitland, Maryland			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.				ADDRESS				25a. REC'D BY REGISTRAR MAY 9 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
VR AISM (5) 5M 1/65													



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

27178

CERTIFICATE OF DEATH

27171

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN Tb 20 days	2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 6208 31st Ave NW	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Winifred	Middle MAXINE	Last JURRIANS	4. DATE OF DEATH Month MAY	Month 13	Doy 1966	Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1901	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS Days 5	Hours 0	Min 0
10. DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOCIOLOGIST			11. KIND OF BUSINESS OR INDUSTRY		12. BIRTHPLACE (County & State, or foreign country) LISBON, NORTH DAKOTA		13. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. FATHER'S NAME Ray Jurrians		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO. NOT AVAILABLE		17. INFORMANT George Jurrians (Bro.) Grand Rapids, Mich.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Constrictive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c) Anemia, Gastrointestinal Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. May 19 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 2, 1966 , to present , that (I) (we) last saw the deceased alive on May 11, 1966 , and that death occurred at 6:30 A.M. , from causes and on the date stated above.									
22a. SIGNATURE John B Umhoe		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/13/66					
22c. PHYSICIAN'S NAME (Type) JOHN B UMHUE MD		22d. ADDRESS 8805 Conn Ave. Chevy Chase Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 17, 1966		23c. NAME OF CEMETERY OR CREMATORIUM WINCHESTER CEMETERY		23d. LOCATION (City or Town) KENT COUNTY, MICHIGAN			
24. FUNERAL DIRECTOR M.W. HYSONG CO INC. ADDRESS Per. Thomas M. Hysong		24b. ADDRESS 1300 N ST. NW WASHINGTON, DC		24c. REC'D BY REGISTRAR MAY 16 1966		24d. REGISTRAR'S SIGNATURE Charles Judge			



1
FOR STATE M
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67172

1 PLACE OF DEATH a. COUNTY Montgomery Maryland		2 USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	c. LENGTH OF STAY IN b. 11 hrs.	c. CITY OR TOWN (If outside corporate limts write RURAL and give nearest town) Silver Spring	d. STREET ADDRESS 2104 Coleridge Drive		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Savus	Middle Vasili	4 DATE OF DEATH May 1 1966		
S SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18/10/60	9 AGE (In years last birthday) 67 yrs	10. UNDER YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurantour		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Rhodes, Greece	
13. FATHER'S NAME Vasili Kamburis		14. MOTHER'S MAIDEN NAME Despina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Wife, Anthe Kamburis Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
DUE TO (b) <u>Coronary Artery Heart Disease</u> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20e. PLACE OF INJRY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Belden R. Reaps</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town or County) <u>1400 Massachusetts</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAPS</u>		22. DATE SIGNED <u>May 2, 1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/4/66		23c. NAME OF CEMETERY OR CREMATORIUM Glenwood Cemetery	
23d. LOCATION (City or Town) (County) (State) Washington, D. C.		23e. RECORD BY REGISTRAR DATE <u>MAY 4 1956</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR <u>The S. H. Hines Co</u>		ADDRESS <u>2801-14th & N.W.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

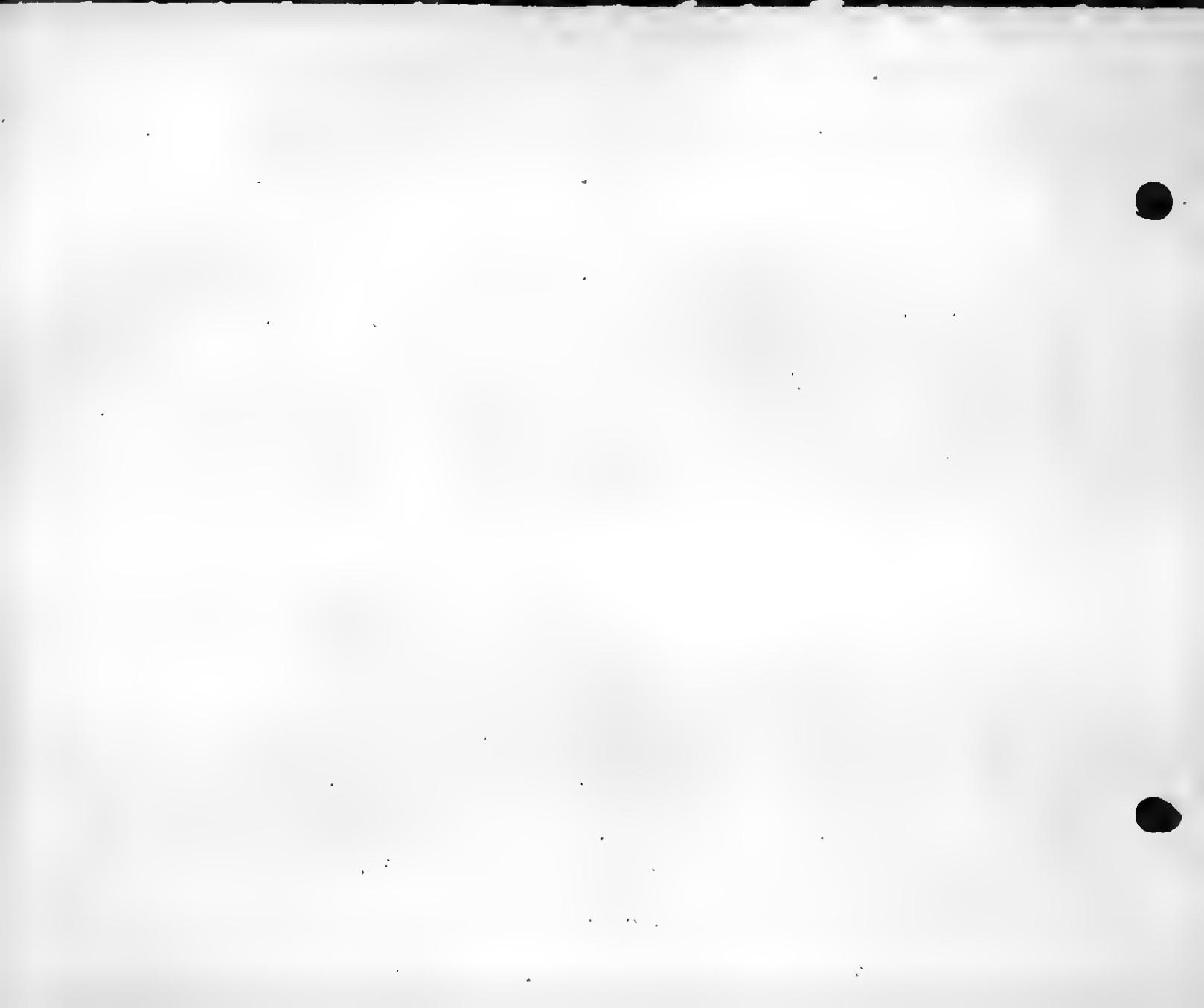
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <i>Montgomery</i>					a. STATE <i>MARYLAND</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>					c. LENGTH OF STAY IN 1b <i>41 days</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington San. & Hosp.</i>					e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>FANNY</i>					First <i>N.M.N.</i>	Middle <i>KAPLAN</i>	Last <i></i>	4. DATE OF DEATH <i>5 - 25 1966</i>	Month Day Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>3-18-86</i>	9. AGE (In years last birthday) <i>80 yrs.</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>					10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (County & State, or foreign country) <i>Lithuanian</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>FREEDMAN, MORRIS</i>					14. MOTHER'S MAIDEN NAME <i>HANNAH ISRAEL</i>	Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Hosp Records</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction due to a CVD</i>		
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					DUE TO (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <i>36 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (a) <i>Bronchopneumia</i> (b) <i>Chronic Pyelonephritis</i>					19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i></i>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>					20d. INJURY OCCURRED <i>While at work</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that <i>(he)</i> (this hospital) attended the deceased from <i>April 14, 1966</i> , to <i>May 25, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 24, 1966</i> , and that death occurred at <i>108 M</i> , from the causes and on the date stated above.					22a. SIGNATURE <i>Gene U. Cohen MD</i>	22b. DATE SIGNED <i>May 25, 66</i>			
22c. PHYSICIAN'S NAME (Type) <i>GENE U. COHEN, M.D.</i>					22d. ADDRESS <i>1106 SPRING ST, SILVER SPRING, MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>					23b. DATE THEREOF <i>5-29-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>GEO. WASH. CEM.</i>	23d. LOCATION (City, town or county) <i>HYATTSVILLE</i>	(State) <i>MD</i>	
24. FUNERAL DIRECTOR <i>Goldberg Funeral Home</i>					ADDRESS <i>4217-9 of St. NW</i>	25a. REC'D BY REGISTRAR <i>OPEN 1 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07174

C7181

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN LD <i>3 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>4410 Dahill Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>WALTER</i>	Middle <i>M</i>	Last <i>Kauffman</i>	4. DATE OF DEATH <i>MAY 4 1966</i>	Month Day Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-20-34</i>	9. AGE (in years) IF UNDER 1 YEAR (last birthday) <i>31</i>	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Crushed Rockville Stone</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
13. FATHER'S NAME <i>Norman Harvey</i>		14. MOTHER'S MAIDEN NAME <i>Jean E. Tye</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no) or unknown		16. SOCIAL SECURITY NO. <i>210-26-7145</i>		17. INFORMANT Address <i>Eloa - wife same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>7936 Old Georgetown Road Bethesda</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>John G. Ball</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>5/4/66</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/7/66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Spring Hill</i>	
23d. LOCATION (City, town or county) <i>Shippensburg, Cumberland Co.</i>		(State)			
24. FUNERAL DIRECTOR <i>Tyson Wheeler</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 6 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>	



1
- FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C7182

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07175

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY	Montgomery		MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Rural	Martinsburg	D.O.A	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Moorefield	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	along Electric Power Lines			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
George	Richard	Keller	May	31	1966				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
M.	W.			9/19/1933	32 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?				
Electric Line Man		West Virginia			U.S.A				
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME								
George W. Keller	Fernanda Timmons								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address						
Yes	Unknown	Beatrice Keller	Zone 52 Avenue						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Insufficiency Acute. 42-1						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b)	Coronary Arteriosclerosis. years					
	DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
19						

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	Bethesda, Md.
ACTUAL SIGNATURE <i>John G. Ball</i>	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 5/31/66
EXAMINER'S NAME (Type)	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION (City, town or county) (State)
Burial	June 2, 1966	Clint Cemetery	Moorefield West Virginia
ADDRESS			
24. FUNERAL DIRECTOR,	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Selby G. Humphrey	JUN 3 1966	Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please sign and give carbon papers (Pages 1 and 2) to the funeral director. Page 3 should be detached for use as the burial permit. Then please sign and give carbon papers (Pages 1 and 2) to the funeral director. After this certificate has been signed by the attending physician, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours of death.

CERTIFICATE OF DEATH								07176			
1. PLACE OF DEATH a. COUNTY Montgomery				MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN lb 22 days				b. COUNTY Montgomery			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General				d. STREET ADDRESS 6 Wesley Court				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Jonathan Sandy		Middle Kemp		Lost 5		DATE OF DEATH Month 23		Day Year 19 66	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 6/27/84		9. AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jacob Kemp				14. MOTHER'S MAIDEN NAME Annie Baker							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Hospital records			Address Olney, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) GENERAL ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 6 hrs 30 min.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSION - PYELONEPHRITIS - UREMIA											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (1) this hospital attended the deceased from October 1963, to 5/23/66, that (1) (we) lost saw the deceased alive on 5/23/66, and that death occurred at 7P M, from causes and on the date stated above.											
22a. SIGNATURE Donald R. Lewis			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 5/23/66					
22c. PHYSICIAN'S NAME (Type) Donald R. Lewis			22d. ADDRESS Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-26-66		23c. NAME OF CEMETERY OR CREMATORIAL Laytonsville				23d. LOCATION (City or Town) (County) (State) Laytonsville, Mont., Md.			
24. FUNERAL DIRECTOR Francis H. Barber			ADDRESS Laytonsville, Md.			25a. REC'D BY REGISTRAR MAY 25 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

57184

CERTIFICATE OF DEATH

07177

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Annapolis	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. STREET ADDRESS 9 Riverbay Rd., Cape St.Clair	
3. NAME OF DECEASED (Type or print) William Medford KEMSKE		4. DATE OF DEATH Month May Day 13 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 21, 1921		9. AGE (in years at birthday) 45 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Ret	
11. BIRTHPLACE (County & State, or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emil J. Kemske		14. MOTHER'S MAIDEN NAME Merle Connolly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> yes give war or dates of service Nov 41-Dec. 65		16. SOCIAL SECURITY NO	
17. INFORMANT Clair, Annapolis Address Maryland Mrs. Mary Kemske, 9 Riverbay Road, Cape St./			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Malignant Melanoma with metastases INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rhodensburg
20f. (City or town) Rhodensburg (County) MD. (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 8 , 1966, to May 13 , 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 13 , 1966, and that death occurred at 1252PM , from causes and on the date stated above			
22a. SIGNATURE Robert H. Easterday		22b. DATE SIGNED 13 May 1966	
22c. PHYSICIAN'S NAME (Type) Robert H. Easterday, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5-14-66	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln
23d. LOCATION (City or Town) Rhodensburg (County) MD. (State)			
24. FUNERAL DIRECTOR Donald J. Taylor ADDRESS John M. Taylor, 147-149 Gloucester St. Annapolis Md.		25a. REC'D BY REGISTRAR MAY 17 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



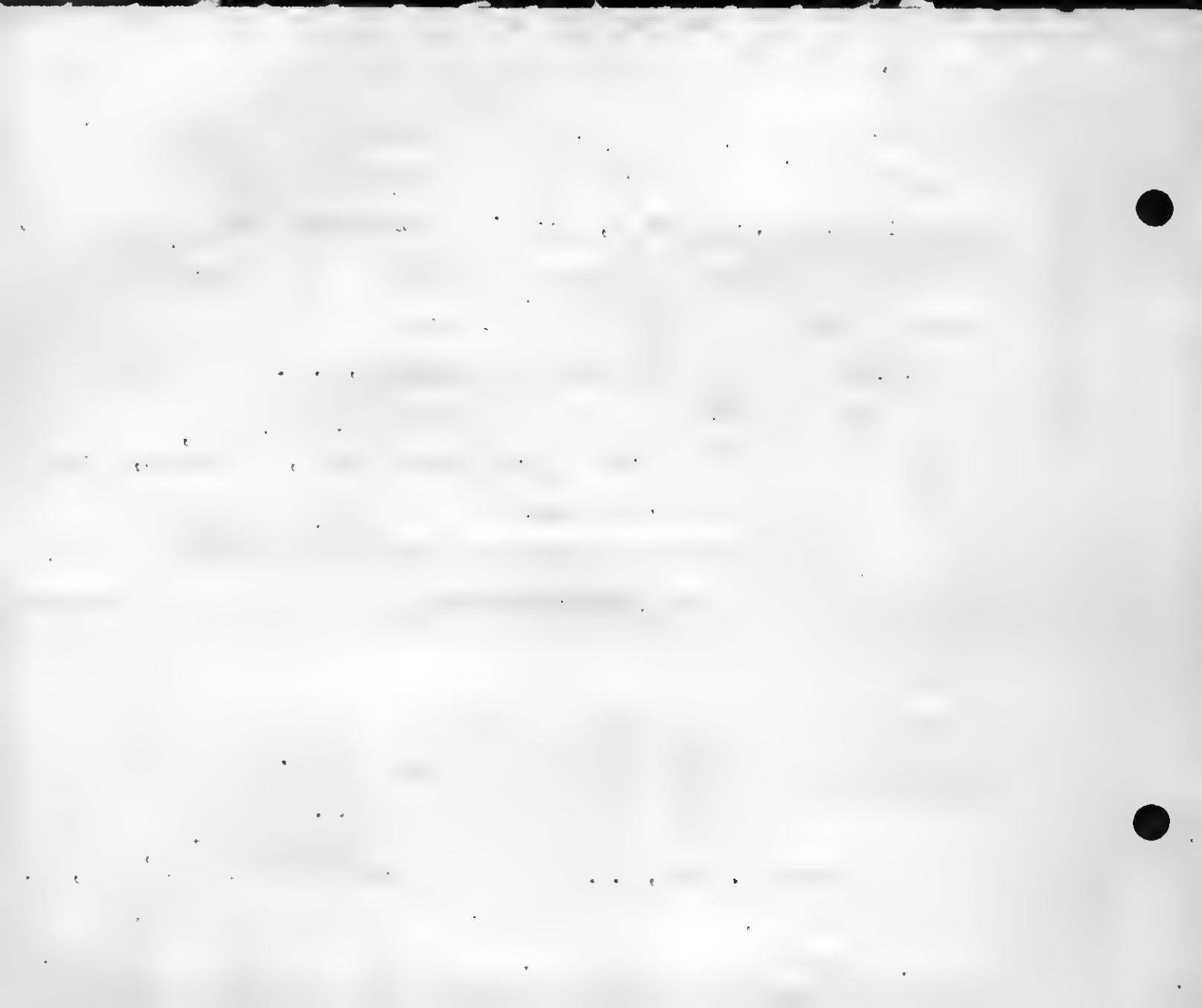
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 7185		2 07178	
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1D 12 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert Joseph Keppler		First Albert	Middle Joseph
4. DATE OF DEATH May 7 1966		Last Keppler	Month May
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 15 April 1958		9. AGE (in years last birthday) 8 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert John Keppler		14. MOTHER'S MAIDEN NAME Helen Kneisly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Records, The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest		INTERVAL BETWEEN ONSET AND DEATH and Cerebral Edema 12 days	
DUE TO (b) Deep coma from Central Nervous System Leukemia/			
DUE TO (c) Acute Lymphocytic Leukemia		30 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 25 April 1966 to 7 May 1966 , that (we) last saw the deceased alive on 7 May 1966 , and that death occurred at 5:25M , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert C. Gallo</i>		A.M. <input type="checkbox"/> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 7 May 1966	
22c. PHYSICIAN'S NAME (Type) Robert C. Gallo, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 10, 1966	
23c. NAME OF CEMETERY OR CROSSLERY Gate of Heaven		23d. LOCATION (City, town or county) (State) "heaton Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md.		25a. REC'D BY REGISTRAR DATE MAY 10 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7186		27179															
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY															
Montgomery MARYLAND		Maryland Montgomery															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 25 years															
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10207 Southmoor Drive		d. STREET ADDRESS 10207 Southmoor Drive															
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year															
Doris Marie Lange		May 30 1966															
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Hours Min.					
Female White						May 27, 1905		61 yrs.									
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.													
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? U. S. A.															
Leonard Mitchell		14. MOTHER'S MAIDEN NAME Marea D. Allen															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Engle Drive Wallingford, Pa.											
None				Yes		William B. Whichard											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Coronary Insufficiency										INTERVAL BETWEEN ONSET AND DEATH					
4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		Coronary Artery Heart Disease.															
(b)		DUE TO															
(c)		DUE TO															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
19																	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) 11502 Grandview Ave. Fort Lincoln, Maryland										22. DATE SIGNED 5/31/1966					
EXAMINER'S NAME (Type) Belden R. Reap																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 1, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		23d. LOCATION (City, town or county) Prince George Co., Md.		(State)									
24. FUNERAL DIRECTOR Joseph Thomas Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR JUN 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge											

EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.



1 M

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with your files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7187		07180	
1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits write RURAL, and give nearest town) Hyattsville	
d. LENGTH OF STAY IN lb Washington Sant Hosp.		d. STREET ADDRESS 902 Linwood St	
3 NAME OF DECEASED (Type or print) Nicola Anthony Lanzillotti		4 DATE OF DEATH Month May Day 11 Year 1966	
e. SEX Male f. COLOR OR RACE White		g. DATE OF BIRTH June 12, 1888	
h. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		i. AGE (in years last birthday) 77 yrs	
j. 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		k. 10b KIND OF BUSINESS OR INDUSTRY None	
l. 11 BIRTHPLACE (State or foreign country) Italy		m. 12 CITIZEN OF WHAT COUNTRY? None	
n. 13 FATHER'S NAME Antonio Lanzillotti		o. 14 MOTHER'S MAIDEN NAME Ciavallini	
p. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) No		q. 16 SOCIAL SECURITY NO 55-32-78	
r. 17 INFORMANT John A. Lanzillotti		s. Address 102 Linwood St, Hyattsville, Maryland	
t. 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Coronary Artery Heart Disease		u. INTERVAL BETWEEN ONSET AND DEATH	
v. (b) Diabetes Mellitus DUE TO			
w. (c)			
x. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		y. 19 WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
z. 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) While at work	
20c. TIME OF INJRY Month, Day, Year Hour o.m. 19		20d. INJRY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJRY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) Hyattsville (County) Maryland (State) Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED May 11, 1966	
23a ACTUAL SIGNATURE Belden R. Papp M.D. EXAMINER'S NAME (Type) BELDEN R. PAPP M.D.		23b CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) 102 Linwood St, Hyattsville, Maryland	
23c BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 16 May 1966		23d LOCATION (City or Town) Hyattsville (County) Maryland (State) Maryland	
24 FUNERAL DIRECTOR John A. Lanzillotti ADDRESS 102 Linwood St, Hyattsville, Maryland		25a REC'D BY REGISTRAR Charles Judge MAY 16 1966 25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.S. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

27188

07181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery county.		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN TB 20 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital of Sil. Spring		d. STREET ADDRESS 10703 Shaftbury Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) LENA	First	Middle NMI	Last LASKEY	4 DATE OF DEATH 5/ 31/ 1966	Month	Day	Year
5 SEX female	6 COLOR OR RACE negro	7 MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 72	9 AGE (In years at birthday) 72	10 UNDER 1 YEAR Months 0	11 UNDER 24 HRS Days 0
10a. USA. OCCUPATION (Give kind of work done during most of working life even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Laskey		14. MOTHER'S MAIDEN NAME Amanda Bowie		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Rachel Pratt, sister, Kensington, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c)							
<i>Acute Coronary Insufficiency</i> <i>Arteriosclerotic Heart Disease.</i>							
INTERVAL BETWEEN ONSET AND DEATH							
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) Belden R. Reap, M.D., Rockville, Md.					
22. DATE SIGNED 5/31/1966							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/4/66	23c. NAME OF CEMETERY OR CREMATORIAL Fish Memorial		23d. LOCATED ON (City or Town) Sandy Spring, Md.		(County) (State)	
24. FUNERAL DIRECTOR Robert L. Snowden Rockville, Md.	ADDRESS	25. FIELD REGISTRATION NUMBER JUN 8 1966		26. AUTOMATRON SIGNATURE John J. Judge		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07189

CERTIFICATE OF DEATH

07182

1. PLACE OF DEATH

a. COUNTY

Montgomery
Bethesda

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban

MARYLAND

c. LENGTH OF STAY IN lb

8hr. 45min

3. NAME OF
DECEASED
(Type or print)

Jane Elizabeth

First Middle

5. SEX

F E W

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

11 May 1918

4. DATE
OF
DEATH

May 19 1966

Month Day Year

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE County & State, or foreign country

13. FATHER'S NAME

James William Laughlin Maude Jane Krebs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECUR.TY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes, give rank or dates of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

174X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.(b)
DUE TO

(c)

None
Pneumonitis

Address 1035 Main St

INTERVAL BETWEEN
ONSET AND DEATH

8 hrs 45 min

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
While at work Not While at work
p.m. 19 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 19, 1966 to May 19, 1966, that (I) (we) last saw the deceased alive on May 19, 1966, and that death occurred at 10:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

James A. Davis Jr. M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.
22b. DATE SIGNED 5/19/66

22c. PHYSICIAN'S NAME (Type)

James A. Davis Jr. 8218 Wisconsin Ave, Bethesda, MD
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESSBurial-transit 5-21-66 Odd Fellows Cemetery Shamokin, Penna.
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATUREROBERT A. PUMPHREY Bethesda, Maryland MAY 25 1966 Charles Judge
VR A15 (4)
15M 9/60



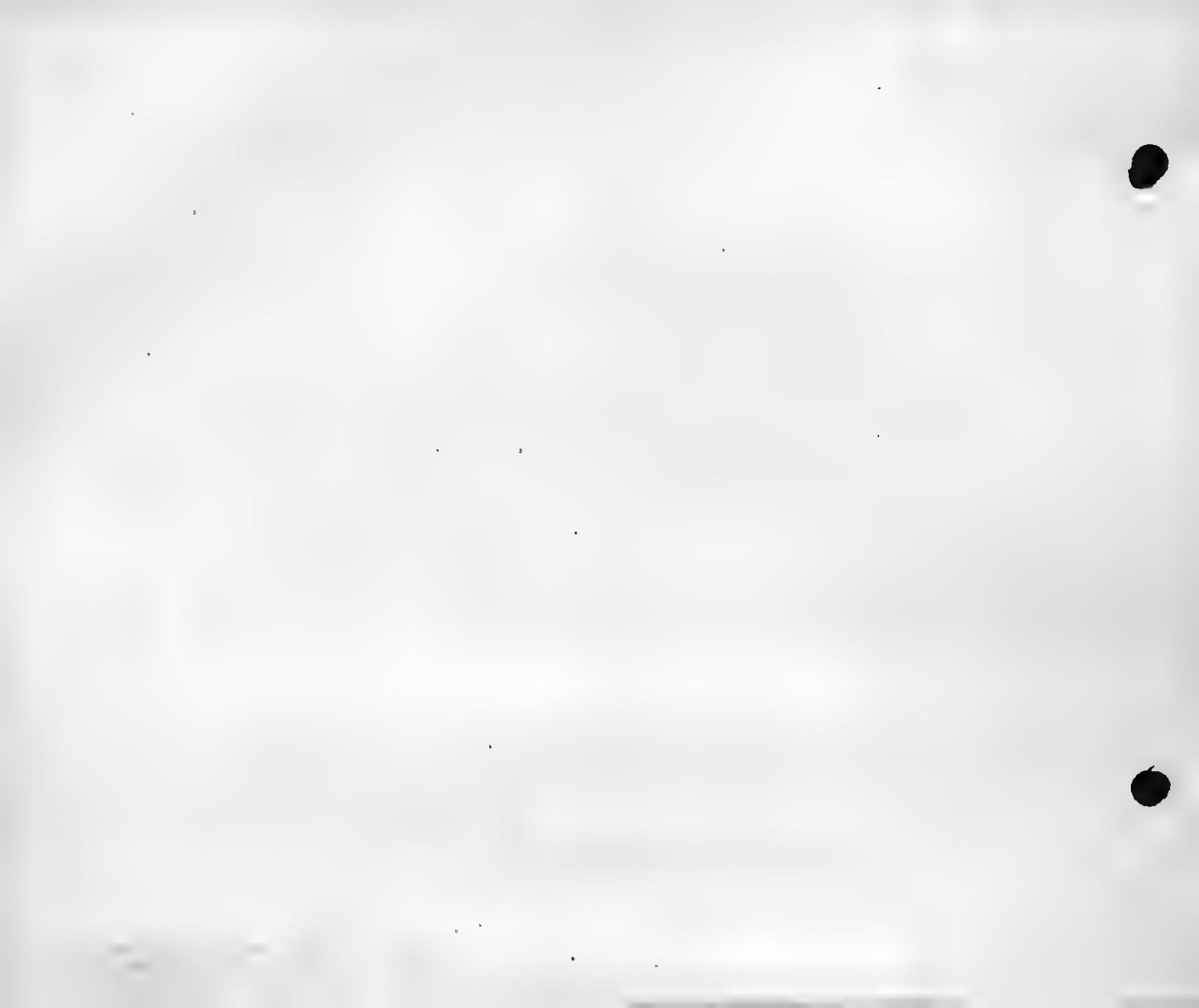
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07183

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac		c. LENGTH OF STAY IN 1b 2 yrs, 1 mo 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 7816 - Old Chester Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Potomac Manor Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X			
3. NAME OF DECEASED (Type or print) Joseph		First A.	Middle Lee	Lost	4. DATE OF DEATH May 20 1966	Month May	Day 20	Year 1966	
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5/5/1881	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Est. & Engr.		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Henry Lee		14. MOTHER'S MAIDEN NAME Elizabeth ?							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 8-24-1907 8-23-1909		17. INFORMANT Mrs. Margaret Lee Higdon (above address)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				(Daughter) <i>cardiac arrest</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		<i>congestive failure</i>		<i>2 days</i>			
DUE TO (c)				<i>A.S., H.P.</i>		<i>2 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				<i>Bronchopneumonia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda		(County) Maryland	(State) Maryland
21. I certify that (I) (this hospital) attended the deceased from June 1965 to May 1966 . Do that (I) <input type="checkbox"/> last saw the deceased alive on May 18 1966 , and that death occurred at 5 AM , from the causes and on the date stated above.									
22a. SIGNATURE <i>Marvin Wadler</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED May 20, 1966					
22c. PHYSICIAN'S NAME (Type) MARVIN WADLER		22d. ADDRESS 8218 Wisconsin Ave, Bethesda, Md.							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/23/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Fort Lincoln Cem. & Garden, Rainier, Maryland		23d. LOCATION (City, town, or county) Bethesda		(State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's						25a. REC'D BY REGISTRAR RECEIVED MAY 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 25b Film G-77 5/26/66 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, 3 to the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>D. C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>D.O.A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washingtonian + Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
f. STREET ADDRESS <i>1512 T St. N.W.</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>WILLIE SIMON LEE JR.</i>		First <i>WILLIE</i>	Middle <i>SIMON</i>
4 DATE OF DEATH <i>5 - 20 1966</i>	Month <i>5</i>	Day <i>20</i>	Year <i>1966</i>
5 SEX <i>Male</i>	6 COLOR OR RACE <i>Negro.</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>3-27-20</i>
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABRER</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>HARTSFIELD S.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Willie Simon Lee</i>		14. MOTHER'S MAIDEN NAME <i>Oleane Sutton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>7</i>		16. SOCIAL SECURITY NO <i>7</i>	
17. INFORMANT		Address <i>1217 So. Pearson St. Raleigh NC.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple, extreme fractures</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>of skull with intraorbital laceration and hemorrhage.</i> (b) <i>Deceased's head crushed by boom on apartment construction site fact.</i> DUE TO (c) <i>Deceased's head crushed by boom on apartment construction site fact.</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <i>Deceased's head crushed by boom on apartment construction site fact.</i>	
20c. TIME OF INJURY Month, Day Year <i>2 20 1966</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <i>apt. Bldg. Takoma Park Montgo. Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>May 20, 1966</i>	
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Raleigh, N.C.</i>	
23a. BURIAL/CREMATION, REMOVAL (Specify) <i>5/21/66</i>		23b. DATE THEREOF <i>5/21/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Morrow & Wood - ADDRESS By Belden R. Reap, M.D., 1622 11th St. N.W. MAY 23 1966</i>
24. FUNERAL DIRECTOR <i>Morrow & Wood - ADDRESS By Belden R. Reap, M.D., 1622 11th St. N.W. MAY 23 1966</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Montgomery MARYLAND		Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Chevy Chase		Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
5480 Wis. Ave.,		5480 Wis. Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Female		Pia	P
S. SEX		6. COLOR OR RACE	7. MARRIED
Female		White	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
House Wife		-	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Dr. Robert Meszlenyi		Elizabeth Popekra	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
No		054 30 9818	
17. INFORMANT		Address	
Dr. Ivan Lenart, 5480 Wis. Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Bronchogenic Carcinoma		9 month	
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), (c)			
DUE TO			
(b)		—	
DUE TO		—	
(c)		—	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 4/10/66, to 5/7/66, 1966, that (I) (we) last saw the deceased alive on 5-7-66, and that death occurred at 545 M, from causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE		22b. DATE SIGNED	
T. Ham II. D.		5-7-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Burial		135 Center St. Vienna, Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		May 9, 1966	
24. FUNERAL DIRECTOR		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
H. Don De Sol		ROCK CREEK CEM. Wash. DC	
23d. LOCATION (City or Town) (County) (State)		23d. LOCATION (City or Town) (County) (State)	
WASHINGTON D.C.		WASHINGTON D.C.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
MAY 12 1966		Charles Judge	



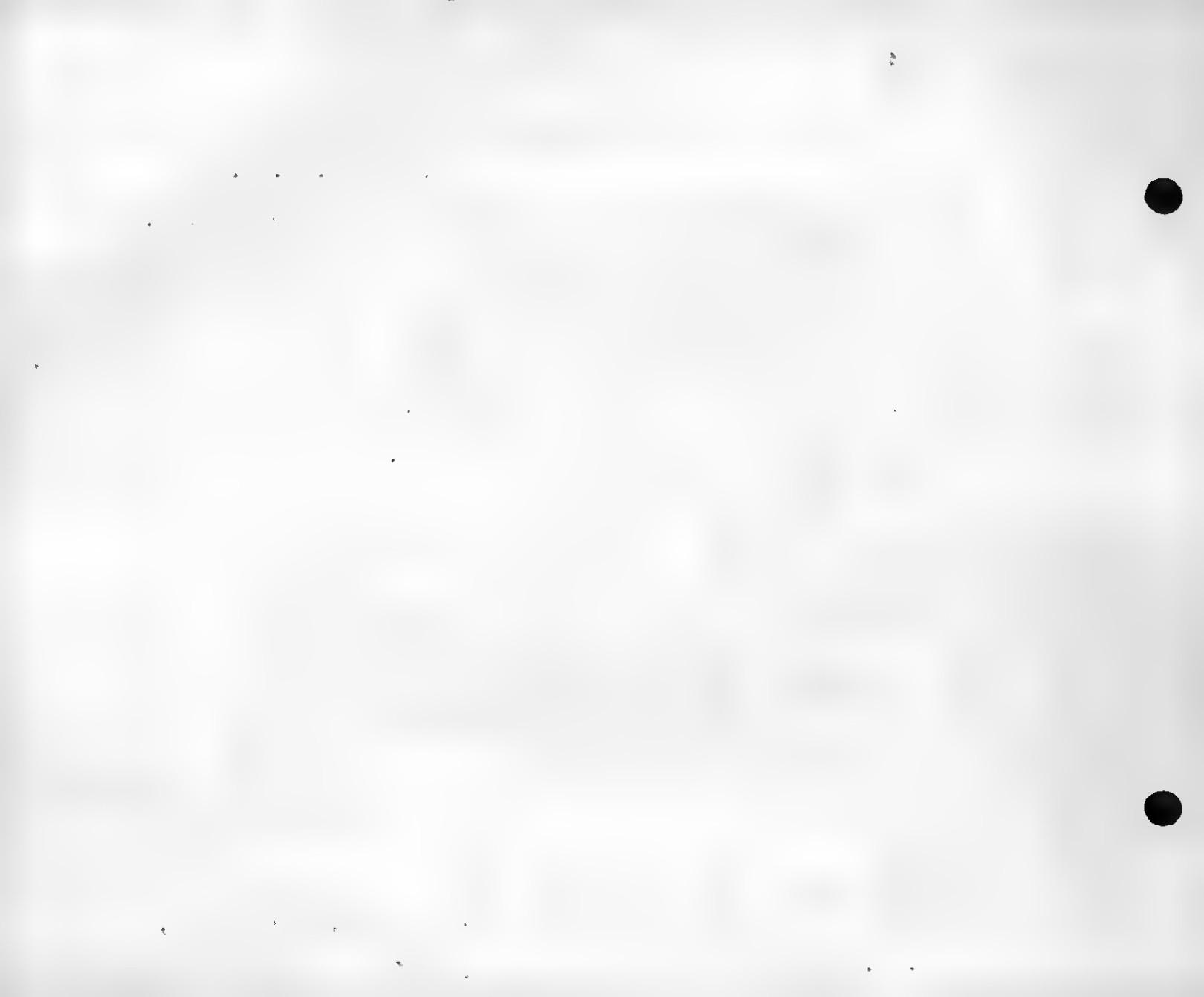
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Washington, D. C.		b. COUNTY	
b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb		c. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium		d. STREET ADDRESS 3000 Tilden Street N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First M. A. SEK	Middle C.	Last Lewis	4. DATE OF DEATH 11 MAY 29 66	Month May	Doy 29	Year 1966
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/1890	9. AGE (In years lost birthday) 75 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	hours 0
10. JSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Indiana			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John B. Stonebraker		14. MOTHER'S MAIDEN NAME Ada A. Garrigus		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) yes WW#1		16. SOCIAL SECURITY NO none		17. INFORMANT Theodore C. Lewis- same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { Coronary insufficiency lost. (b) DUE TO (c) Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) None		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
20e. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20f. (City or town) (County) (State) None		20g. (City or town) (County) (State) None			
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ M, fram causes and on the date stated above.							
22a. SIGNATURE H. B. C. Inc.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/2/66			
22c. PHYSICIAN'S NAME (Type) J. H. B. C. Inc.		22d. ADDRESS 5005 Corn Ave. Philadelphia, PA					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/2/66	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR The S. H. Hines Company	ADDRESS Washington, D.C.	25a. REC'D BY REGISTRAR JUN 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07187

1
 To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
f. STREET ADDRESS 3182 Key Blvd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Marion	Middle Nethery	Last LITTLE
4. DATE OF DEATH May 23 1966	Month May	Day 23	Year 1966
5. SEX M	6. COLOR OR RACE Cauc.	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH August 5, 1899	9. AGE (In years from last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Mobile, Alabama	
13. FATHER'S NAME James Little	14. MOTHER'S MAIDEN NAME Indel Roberts	12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service yes 1922-1952	16. SOCIAL SECURITY NO 578-48-2894	17. INFORMANT CDR James G. Little, USN 3182 Key Blvd./	Address Arlington, Va.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 1. Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a). storing the underlying cause lost. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 830A M.
20f. (City or town) U. S. Naval Hospital, Bethesda, Md.		(County) Bethesda	(State) Md.
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 22, 1966 , to May 23, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 23, 1966 , and that death occurred at 830A M. from causes and on the date stated above.			
22a. SIGNATURE J. C. Johnson		M.D. <input type="checkbox"/> ATTENDING PHYS. J. C. Johnson, M. D.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22b. DATE SIGNED 23 May 1966		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/26/66	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery
23d. LOCATION (City or Town) Arlington, Virginia		(County) Arlington	(State) Virginia
24. FUNERAL DIRECTOR Ives Funeral Home		ADDRESS J. C. Gray 2847 Wilson Blvd. Arlington, Va.	25a. REC'D BY REGISTRAR D. J. Gray
			25b. REGISTRAR'S SIGNATURE MAY 25 1966 Charles J. Gray



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												07188			
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		Maryland		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Kensington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Silver Spring		15 - 1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Kensington Gardens				d. STREET ADDRESS		25 Lower Court				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First George	Middle	Last Lockwood	4. DATE OF DEATH	Month MAY	Day 18	Year 1966							
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED WIDOWED		8. DATE OF BIRTH Nov. 14, 1885		9. AGE (In years/last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry Lockwood				14. MOTHER'S MAREN NAME Harriett Washburn											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		NO		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		Linda Lockwood - same as #2d										INTERVAL BETWEEN ONSET AND DEATH 6 weeks.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive heart failure													
+ Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		Generalized arteriosclerotic cardiovascular dis										3-4 yrs.	
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		N/A													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
19		Not While at work													
21. I certify that (I) this hospital attended the deceased from 1960 to 1800, 1966, that (I) we last saw the deceased alive on 18 May 1966, and that death occurred at 7:38 P.M. from the causes and on the date stated above.															
22a. SIGNATURE Eusebio L. Johnson		M.D. ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22b. DATE SIGNED 18 May 66							
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 5-19-66		23c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory		23d. LOCATION (City, town or county) Washington, D.C.		(State)							
24. FUNERAL DIRECTOR Lee Funeral Home		ADDRESS 44th & Mass. Ave., N.E.				25a. REC'D BY REGISTRAR DATE MAY 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

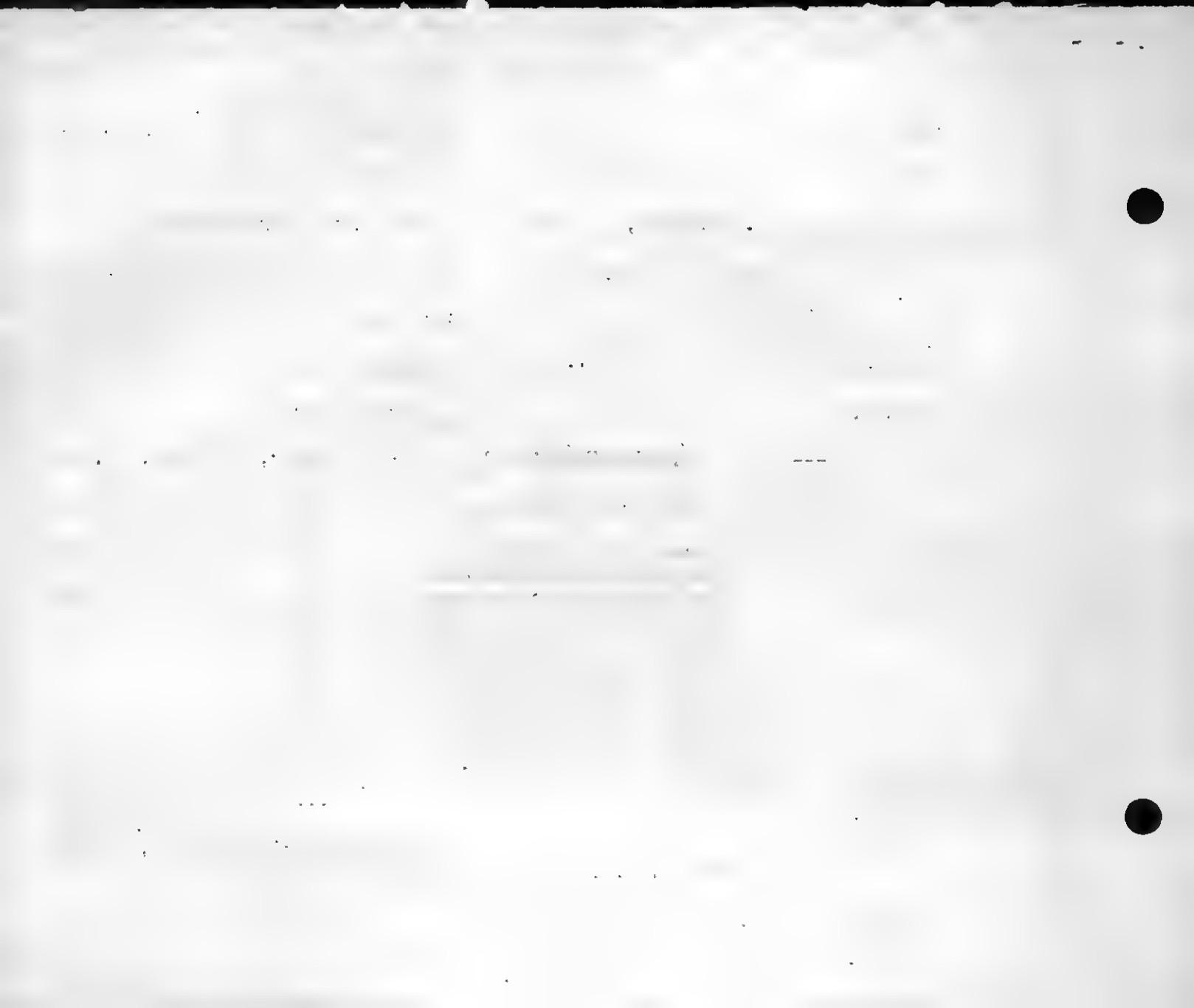
CERTIFICATE OF DEATH

C7189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

27196		CERTIFICATE OF DEATH									
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)									
a. COUNTY Montgomery		a. STATE Maryland									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		b. COUNTY Montgomery									
c. LENGTH OF STAY IN 1b 106 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS 613 West Montgomery Avenue									
3. NAME OF DECEASED (Type or print) Detlef Deitemar		First Detlef	Middle Deitemar	Last Loss	4. DATE OF DEATH May 12, 1966	Month May	Day 12	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 13 March 1942	9. AGE (in years last birthday) 24 yrs.	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS Days 29	12. IF UNDER 24 HRS Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Typist		10b. KIND OF BUSINESS OR INDUSTRY Federal Government		11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Edwin T. Loss		14. MOTHER'S MAIDEN NAME Elvira Kotcerke									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis											
4344 DUE TO (b) Brain stem infarction											
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Multiple emboli secondary to possible cardiac damage											
5 months											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
3 years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) ---		(County) ---		(State) ---	
21. I certify that OK (this hospital) attended the deceased from Jan. 26, 1966 , to May 12, 1966 , that 10 (we) last saw the deceased alive on May 12, 1966 , and that death occurred at 2:35 P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Phillip Yarnell, M.D.</i>		22b. DATE SIGNED A.M. 12 May 1966									
22c. PHYSICIAN'S NAME (Type) Phillip Yarnell, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-14-66		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) Rockville, Maryland		(State) ---			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAY 17 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

37197

CERTIFICATE OF DEATH

37190

1
Cleared & Ned. Examiner
Ex-
uted within 24 hours after death.

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1b 5 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 10212 MERIDITH AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Pauline	Middle	Last Louie
4. DATE DEATH	Month MAY	Day 30	Year 1966
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/13
9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS. Days 9	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY HOCKMAN	14. MOTHER'S MAIDEN NAME ELIZA SAGER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. UNKNOWN.	17. INFORMANT Hattie Hockman	Address Winchester, Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE			
DUE TO (b) SHOCK			
DUE TO (c) HEMORRHAGING PEPTIC ULCER 10 HRS			
INTERVAL BETWEEN ONSET AND DEATH 30 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August 19, 1965 , to 5-20-1966 , that (I) (we) last saw the deceased alive on 5-20-1966 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE John S. Rogers		22b. DATE SIGNED 5-21-66	
22c. PHYSICIAN'S NAME (Type) JOHN S. ROGERS		22d. ADDRESS 269 Lexington St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-24-66	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hebron		23d. LOCATION (City, town or county) (State) Winchester, Va.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR MAY 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

27198

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27197

1. PLACE OF DEATH
a. COUNTY

Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits,
write RURAL and give nearest town)

KENSINGTON 11 DAYS

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

KENSINGTON GARDENS

3. NAME OF
DECEASED
(Type or print)

First ELLA

Middle

Last

4. DATE
OF
DEATH

Month MAY

Day 3

Year 1966

5. SEX

FEMALE

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

July 11 1875

9. AGE (in years
last birthday)

90 yrs.

10. IF UNDER 1 YEAR

Months 0 Days 0 Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Treasury Dept. U. S. Government

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Mash. D.C.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas T Luckett

14. MOTHER'S MAIDEN NAME

TERESA FENTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Marguerite Connors Washington, DC

Address 5306 14th St NW

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4201

OUT TO

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

OUT TO

(c)

Acute Coronary Insufficiency

Arteriosclerotic Heart Disease.

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

NAME (Type)

Belden R. Reap M.D. *attending* May 3, 1966

CHIEF MEDICAL EXAMINER

M.O. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, City, Town, or County)

22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

Burial

5/6/66

Congressional Cemetery Washington, D. C.

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

The S.H. Hines Co.

May 5 1966 Charles Judge

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>5 da 6 hr</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. STREET ADDRESS <i>Boyd's</i>	
3. NAME OF DECEASED (Type or print) <i>Eleanor F. Maughlin</i>		f. DATE OF DEATH Month Day Year <i>5 18 66</i>	
4. SEX <i>F.</i>		5. COLOR OR RACE <i>Law</i>	6. MARRIED NEVER MARRIED WIDOWED DIVORCED <input checked="" type="checkbox"/>
7. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		8. DATE OF BIRTH <i>11/7/82</i>	
9. AGE (In years last birthday) <i>89 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min <i>4 18 0 0</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alfred Gay</i>		14. MOTHER'S MARRIED NAME <i>Eleanor Hatch</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No.</i>		16. SOCIAL SECURITY NO <i>216-40-8507</i>	
17. INFORMANT <i>Daughter</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO <i>4201</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i></i>		(b) DUE TO <i>Coronary Thrombosis</i> (c) DUE TO <i>Coronary Arteriosclerosis</i>	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
20a. MEDICAL CERTIFICATION		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>C-H-7.</i>	
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20e. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20f. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20g. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <i></i>
20h. (City or town) <i></i>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5/1/66</i> to <i>5/18/66</i> , that (I) (we) last saw the deceased alive on <i>5/18/66</i> , and that death occurred at <i>10 AM</i> , from causes and on the date stated above		22b. DATE SIGNED <i>5/19/66</i>	
22c. SIGNATURE <i>Stephen N. Jones</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <i>STEPHEN N. JONES</i>		22d. ADDRESS <i>809 Viers Mill Rd., Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-21-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Boyd's Presby Ch. Cem.</i>
23d. LOCATION (City or Town) <i>Boyd's, Maryland</i>		(County) (State)	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>		25a. ADDRESS <i>Bethesda, Maryland</i>	25b. REC'D BY REGISTRAR <i>MAY 23 1966</i>
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Page 1 and 2, director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2, director, page 3, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

37208 37193

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
Montgomery		Takoma Park		18 days		a. STATE	b. COUNTY		
						Washington D.C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Washington Sanitarium & Hospital						Washington D.C.			
e. IS RESIDENCE ON A FARM?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Helen	Marie	Mayer		May	22	1966			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 YEAR IF UNDER 24 HRS.			
Female	White			3-29-96	70 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Retired - Gov't Worker		D. C.		U.S.A.					
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME								
Robert J. Mayer	Anna Wall								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY ND.	17. INFORMANT	Address						
None	Unknown	Records - Washington San & Hospital							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
4 / ! DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE CVA									
DUE TO Severe generalized arteriosclerosis (c) 6 Rys Prior Several yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4x of Ca breast (mamectomy) Severe psychotic depression									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
19									
21. I certify that (I) this hospital attended the deceased from Jan, 1966, to 5-22, 1966, that (I) we last saw the deceased alive on 5-21 1966, and that death occurred at 2:40 A.M., from the causes and on the date stated above.									
22a. SIGNATURE R. H. Sandstrom									
22b. DATE SIGNED 5/22/66									
22c. PHYSICIAN'S NAME (Type) R.H. Sandstrom MD		22d. ADDRESS 7701 Carroll Ave Takoma Park, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-25-1966	23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery Silver Spring, Md	23d. LOCATION (City, town or county) MAY 25 1966	(State)				
24. FUNERAL DIRECTOR Joseph Lawler's Sons, Inc. Wash.D.C.		ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge					
5100 Wisconsin Ave. N.W.									
VR A15 (4) 20M 1/65									



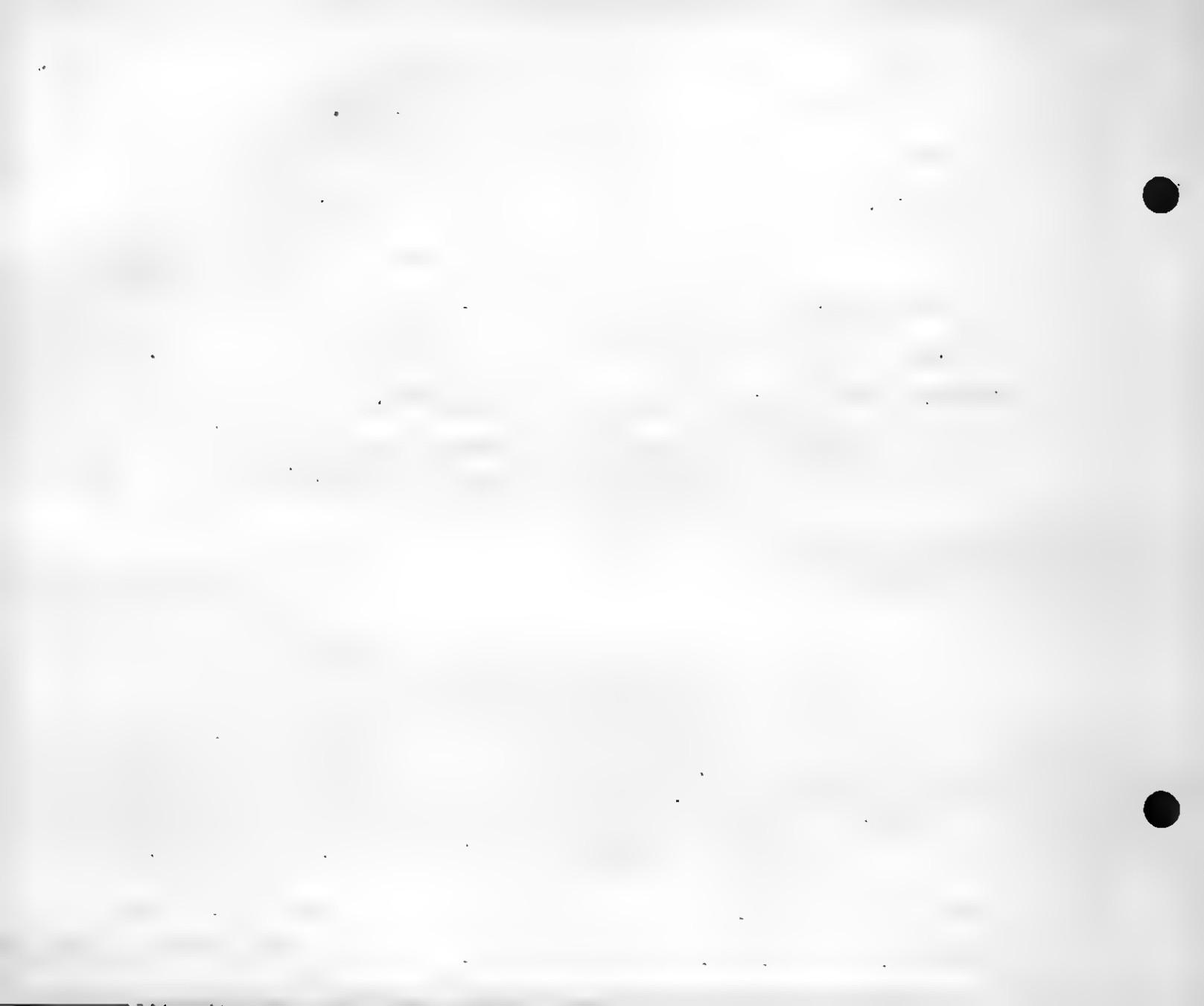
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Wheaton		b. COUNTY		Montgomery			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Wheaton			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2611 Weisman Road		d. STREET ADDRESS		2611 Weisman Road			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Female		Theresa	Katherine	McDonnell	Oct. 15, 1892	73 yrs.	5	30 1966	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 15, 1892	73 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Our home		Ireland		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Jeremiah Keaney		Katherine (?)							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		2611 Weisman Rd.			
No		None		Gregory McDonnell		Wheaton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO (b)		FIBROSIS (HUMAN RICIT-SYND)		18 mos.			
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
				19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____ M, from the causes and on the date stated above.				449, 1965, to 5/30, 1966		22b. DATE SIGNED 5/30/66			
22a. SIGNATURE <i>David Goldenberg</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		1620 Georgia		Silver Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)			
Burial		June 2, 1966		Gate of Heaven Cemetery		Silver Spring, Maryland			
24. FUNERAL DIRECTOR		C. Glen Carter ADDRESS Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE JUN 2 1966 Charles Judge			
VR A15 (4) 20M 1/65									



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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27202		67195								
1. PLACE OF DEATH COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Talsoma Park		b. COUNTY Montgomery								
c. LENGTH OF STAY IN lb 3 - 23 - 66 to 5 - 27 - 66		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium		d. STREET ADDRESS Avenue 9601 Bonair Street								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) Dale Roger McGrail		First Dale	Middle Roger	Last McGrail	4. DATE OF DEATH May 27 1966	Month May	Day 27	Year 1966		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 11-6-46		9. AGE (In years last birthday) 19 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Joseph E. McGrail		14. MOTHER'S MAIDEN NAME Ella Dix								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service No		16. SOCIAL SECURITY NO YES		17. INFORMANT Chart-Washington Sanitarium I.P.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic osteogenic Sarcoma		INTERVAL BETWEEN ONSET AND DEATH 1 yr.								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Right Hemiplegia from Left Cerebral Embolism				19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —	(State) —	
21. I certify that (I) (this hospital) attended the deceased from 5-29 1966 to 5-27 1966 , that (I) (we) last saw the deceased alive on 5-26 1966 , and that death occurred at 2:30 P.M. from causes and on the date stated above.										
22a. SIGNATURE Russell B. Arnold		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/27/66		
22c. PHYSICIAN'S NAME (Type) Russell B. Arnold, M.D.		22d. ADDRESS 1106 Spring St., Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 31 May 66		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln		23d. LOCATION (City or Town) Prince Georges Co., Md.		(County) —	(State) —	
24. FUNERAL DIRECTOR Frank Thomas		8434 ADDRESS Warren E. Pumphrey, Inc.		25a. REC'D BY REG STRR. JUN 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				



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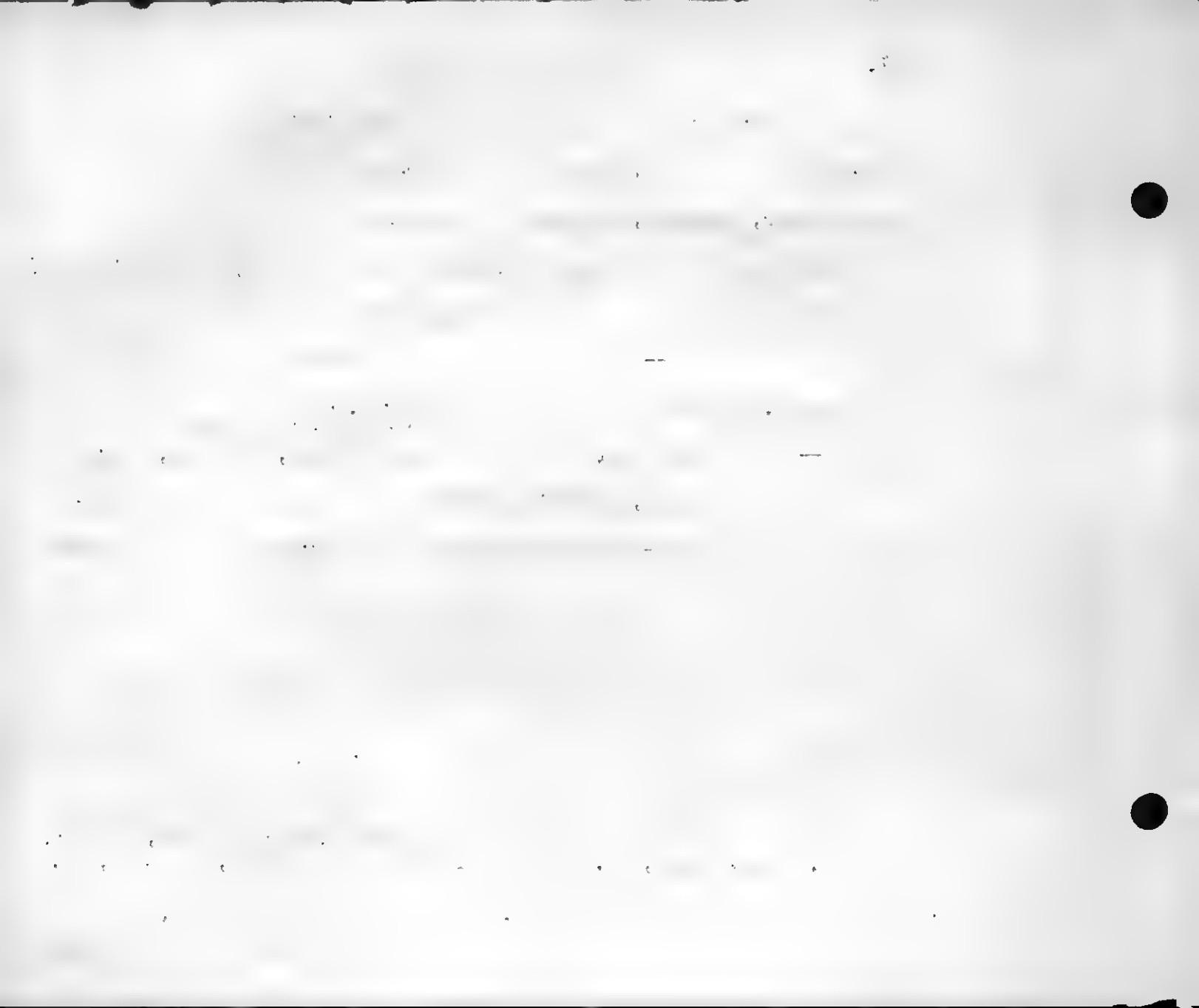
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07196

27203

1. PLACE OF DEATH a. COUNTY	Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)	West Virginia		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	Bethesda 13 Days			b. STATE	b. COUNTY		
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	The Clinical Center, Bethesda, Maryland			Barrett	d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Anthony	George	McGuire	May 4 1966	5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED <input checked="" type="checkbox"/>
Male	White	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		21 July 1947	18 yrs.	Months	Days Hours Min.
Student		--		11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME		George W. McGuire		West Virginia	USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	Address		
No		Not Available		Betty J. Hall	The Medical Record		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis, probably bacterial 1992 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intra-abdominal malignancy undetermined DUE TO (c)		4 Days					
3 Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 21 April 1966, to 4 May 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4 May 1966, and that death occurred at 9:10A, from the causes and on the date stated above.		22b. DATE SIGNED					
22a. SIGNATURE <i>H. Thomas Foley, M.D.</i>		22b. DATE SIGNED 4 May 1966					
22c. PHYSICIAN'S NAME (Type) H. Thomas Foley, MD.		ATTENDING M.D. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 7 1966		23c. NAME OF CEMETERY OR CREMATORIUM Boone Memo. Park		23d. LOCATION (City, town or county) (State) Arnoldson, W Va.	
24. FUNERAL DIRECTOR		ADDRESS Pearson Funeral Home Falls Church, Va.		25a. REC'D BY REGISTRAR MAY 6 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE M
HEALTH DEPT.

57204

07197

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <i>Montgomery</i> b CITY OR TOWN (If outside corporate limts, write RURAL and give nearest town) <i>Bethesda</i>		2 USUAL RESIDENCE (Where deceased lived) a STATE <i>Maryland</i> b COUNTY <i>Montgomery</i>	
c LENGTH OF STAY IN b <i>10 days</i>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d STREET ADDRESS <i>8004 Hampden Ln</i>	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <i>Kate</i>	First <i>F</i>	Middle <i>M</i>	Last <i>Mears</i>
4 DATE OF DEATH Month <i>MAY</i>	Day <i>6</i>	Year <i>1966</i>	
5 SEX <i>F</i>	6 COLOR OR RACE <i>W</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>8/31/1867</i>
9 AGE (In years, last birthday) <i>98 yrs</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>---</i>	10c. BIRTHPLACE (State or foreign country) <i>Meckersburg, Pa</i>	12 CITIZEN OF WHAT COUNTRY? <i>USA</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	13 FATHER'S NAME <i>John</i>	14 MOTHER'S MAIDEN NAME <i>Maria</i>	15 ADDRESS <i>Spangler</i>
S WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <i>No</i>	16 SOCIAL SECURITY NO <i>Unknown</i>	17. INFORMANT <i>Miss Florence Mears-Same as Item #2</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Arterio-Sclerosis -</i> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause <i>Arterio-Sclerosis -</i> lost <i>Arterio-Sclerosis -</i> (b) <i>Arterio-Sclerosis -</i> DUE TO (c) <i>Arterio-Sclerosis -</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fracture of RT-Hip.</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Fell at nursing home-causing fracture of RT-Hip.</i>	
20c. TIME OF INJURY Month Day Year Hour <i>4</i> pm <i>4/26</i> <i>1966</i>		20d. INJURY OCCURRED When <input type="checkbox"/> Not while at work <input type="checkbox"/> or of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc) <i>Nursing Home -</i>
20f. (City or Town) <i>Silver Spring Mont. Md</i>		(County) <i>Prince George Co.</i>	(State) <i>Md</i>
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John G. Ball</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>5/6/66</i>
EXAMINER'S NAME (Type) <i>John G. Ball</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <i>Prince George Co., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	23b. DATE THEREOF <i>5/6/1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Crematory</i>	23d. LOCATION (City or Town) <i>Prince George Co., Md.</i>
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey Bethesda, Maryland</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>MAY 9 1966</i>	25b. REGISTER'S SIGNATURE <i>Charles Judge</i>
VR A15ME (5) 6M 1/66			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												07198					
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY MONTGOMERY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BOYDS			c. LENGTH OF STAY IN 1b MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND			b. COUNTY MONTGOMERY					
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Maryland			e. STREET ADDRESS BOYDS			f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			15								
3. NAME OF DECEASED (Type or print)		First CLARA	Middle M.	Last MELVIN	4. DATE OF DEATH	Month May	Day 11	Year 1966	5. SEX		6. COLOR OR RACE Female White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIOOWEO <input type="checkbox"/> OIVORCEO <input type="checkbox"/> Jan. 27, 1915	9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR 3	11. IF UNDER 24 HRS 14	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME JOHN E. COLE			14. MOTHER'S MAIDEN NAME MARY NICHOLS														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Walter P. Melvin same item #2 - Husband		Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO												INTERVAL BETWEEN ONSET AND DEATH Montus Years Years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MAY 2, 1966			20f. (City or town) (County) (State) Maryland		
21. I certify that (I) (this hospital) attended the deceased from MAY 2, 1966 , to MAY 11, 1966 , that (I) (we) last saw the deceased alive on MAY 9, 1966 , and that death occurred 10a M, from the causes and on the date stated above.			22a. SIGNATURE Jack Schumacher			22b. DATE SIGNED 5-11-66			22c. PHYSICIAN'S NAME (Type) Jack Schumacher			22d. ADDRESS 105 Russell Ave., Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 5/14/66			23c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery			23d. LOCATION (City, town or county) (State) Barnesville, Maryland								
24. FUNERAL DIRECTOR			ADDRESS Tyson Wheeler Funeral Home 1331 Rockville Rd. Rockville, Md.			25a. REC'D BY REGISTRAR MAY 13 1966			25b. REGISTRAR'S SIGNATURE Charles Judge								
VR A15 (4) 20M 1/65																	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07206

CERTIFICATE OF DEATH

07193

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
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2. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE	
Montgomery MARYLAND		Maryland Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
5209. Chamberlain ave		5209. Chamberlain ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
ALICE S. C. MERCHANT			Last
4. DATE OF DEATH		Month	Day Year
May. 18th 1966 19			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Vol worker		Red Cross	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ohio			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Amadeus Martin Coghlin		Clair Irvine.Coghlin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
James R. Murphy Executor			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>7201</i> DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Coronary insufficiency as best - selective H. b. d.s.</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from <i>1943 to 5-18</i> , 1966, that (I) (we) last saw the deceased alive on <i>5-18</i> 1966, and that death occurred at <i>1:30</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Paul J. Landor</i>			
22b. DATE SIGNED <i>5-18-66</i>			
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>5.19.66</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Lee's Crematory</i>		23d. LOCATION (City, town or county) (State) <i>Washington D.C.</i>	
24. FUNERAL DIRECTOR <i>Lee Funeral Home 300. 14th st N E</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
		25b. REGISTRAR'S SIGNATURE	

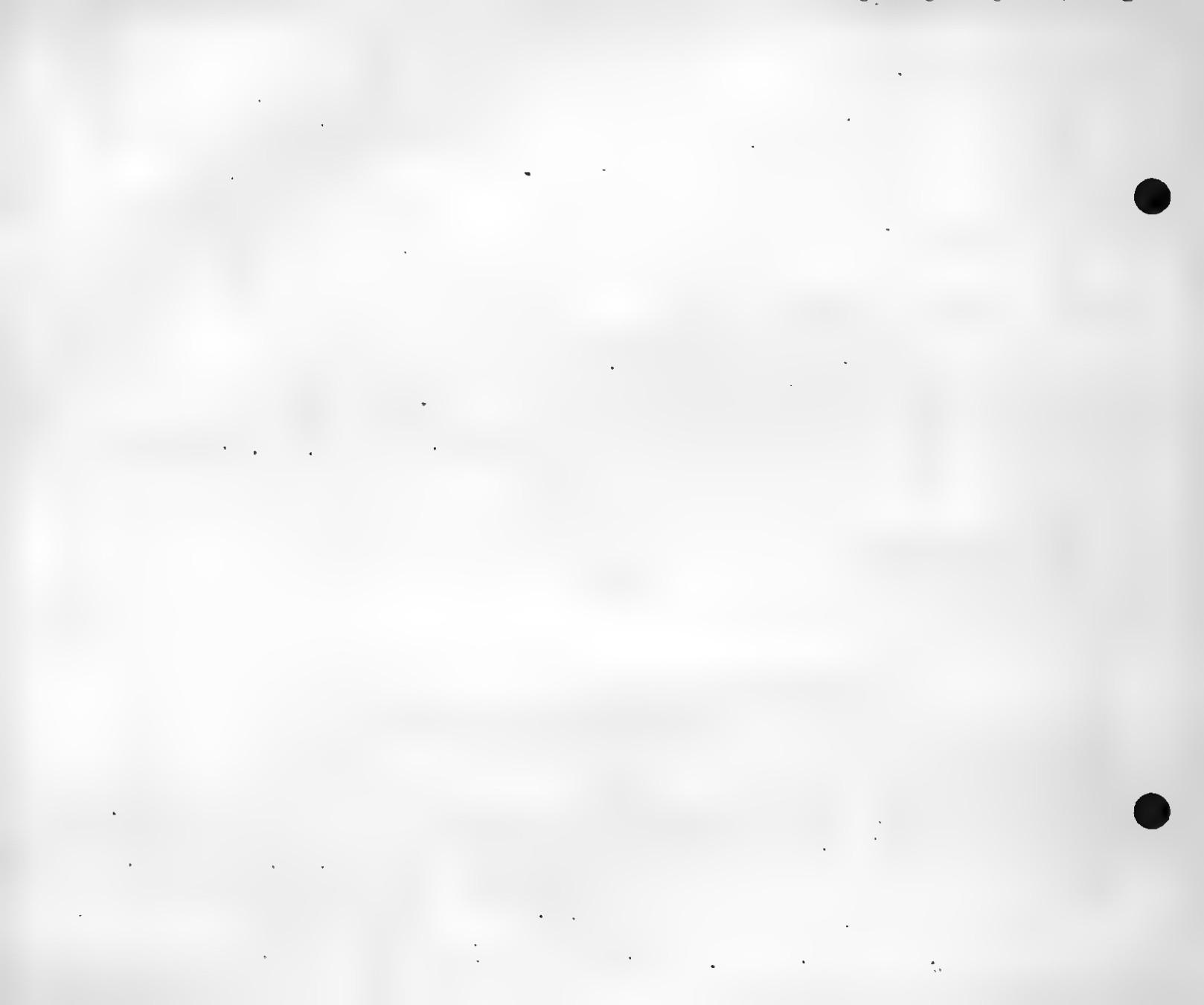


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												Item 14, Film G 376 5/20/66 JN	CERTIFICATE OF DEATH	37200					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				a. STATE				b. COUNTY							
Montgomery				MARYLAND				Maryland				Montgomery							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN MD				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				d. STREET ADDRESS							
Silver Spring				years				Silver Spring				15450 Thompson Rd							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)								e. IS RESIDENCE ON A FARM?											
15450 Thompson Road								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years) last birthday	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours		
Female		White	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	Feb. 22, 1881	85 yrs.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY							
Homemaker				At Home				Kansas				U.S.A.							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
Frances Morrison				Mary Abbott Sharp				No								Address			
Daughters - 15450 Thompson Rd S.																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO (b)				Respiratory Failure											
				DUE TO (c)				Cerebral Thrombosis				7 days							
				Generalized Arteriosclerosis								years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
19																			
21. I certify that (I) (this hospital) attended the deceased from July 1966, to May 11, 1966, that (I) (we) last saw the deceased alive on May 2, 1966, and that death occurred at 12:00 M. from the causes and on the date stated above.												22b. DATE SIGNED 5/11/66							
22a. SIGNATURE Joseph E. Smith, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. ADDRESS Bartonsville, Md.											
22c. PHYSICIAN'S NAME (Type) Joseph E. Smith, Jr.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 13, 1966				23b. DATE THEREOF May 13, 1966				23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City, town or county) Rockville				(State) Md			
24. FUNERAL DIRECTOR Arthur Waller, 254 Carroll St NW 10C				ADDRESS				25a. REC'D BY REGISTRAR MAY 13 1966				25b. REGISTRAR'S SIGNATURE Charles Judge							



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

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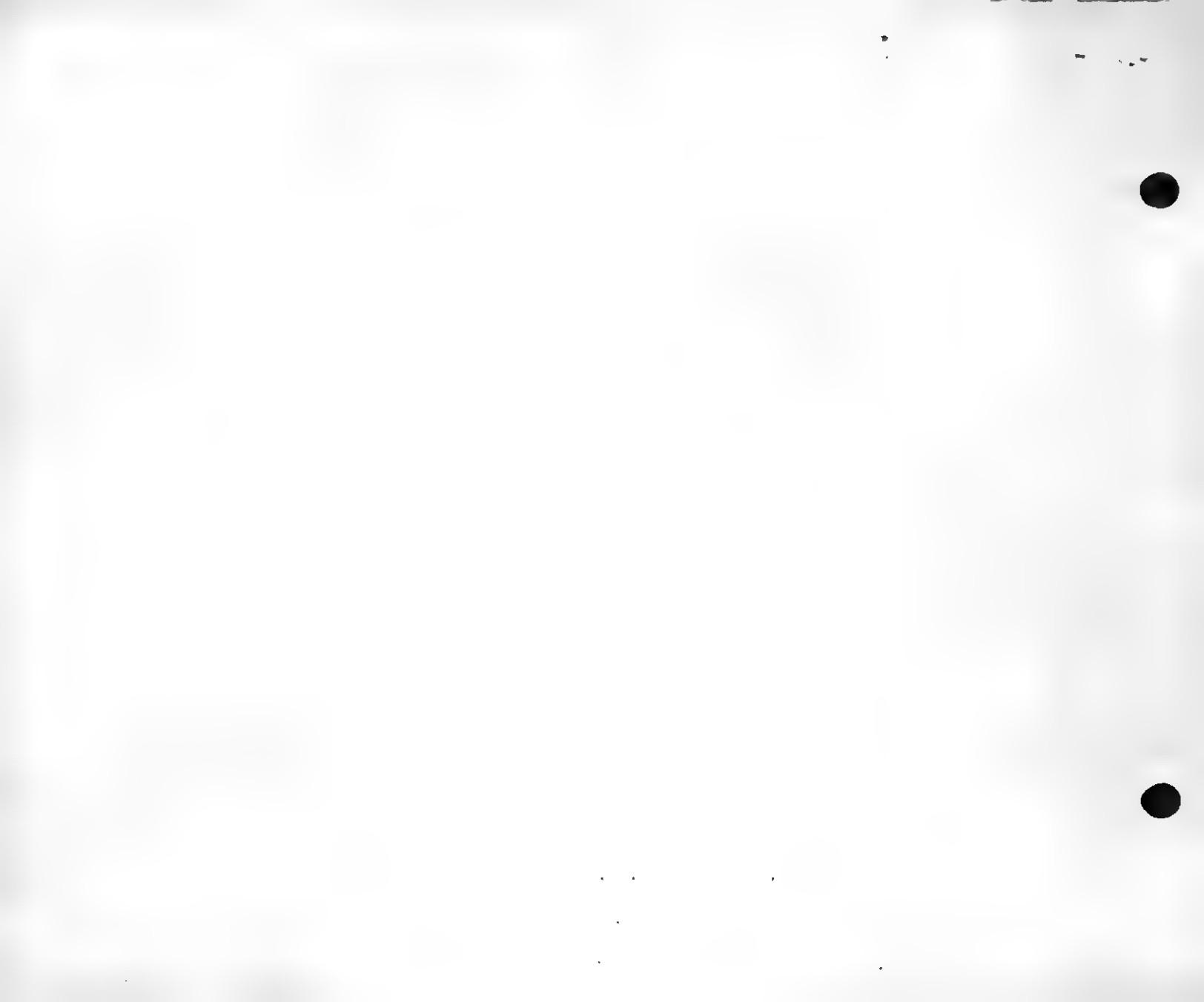
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

C7208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7201

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print)		First	Middle
3 NAME OF DECEASED (Type or print)		3 DATE OF DEATH	Month Day Year
S SEX	6 COLOR OR RACE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH 9 AGE (In years lost birthday) Yrs Months Days Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)
13 FATHER'S NAME		14 MOTHER'S MAIDEN NAME	12 CITIZENSHIP OF WHAT COUNTRY?
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service		16. SOCIAL SECURITY NO.	17 INFORMANT Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) DUE TO (c)	Fracture of Right Hip - - - - - 2 months.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) arthritis - generalized -			
20a EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fall at home - 1 March 1966	
20c TIME OF INJURY Month, Day, Year Hour am pm 31 1966		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		20f (City or town) (County) (State) Woodbine Cape May N.J.	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Bethesda, Maryland	
23a BURIAL, CREMATION, CENOTAPH (Specify) Burial		23b. DATE THEREOF 5/27/1966	
23c NAME OF CEMETERY OR CREMATORIALy		23d LOCATION (City or Town) (County) (State) Mt. Pleasant Millville New Jersey	
24 FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Maryland		ADDRESS 25a REC'D BY REGISTRAR MAY 27 1966	
		25b REGISTRAR'S SIGNATURE Charles Judge	



1 M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give copies 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiners Office along with Form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Missouri							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b MARYLAND							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kansas City							
3. NAME OF DECEASED (Type or print) Donald Wayne MILLER				4. DATE OF DEATH Month May 2 1966				6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1945		9. AGE (in years last birthday) 20 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Booneville, Missouri			
13. FATHER'S NAME Paul Reed Miller				14. MOTHER'S MAIDEN NAME Frances Irene Allen				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 492-46-3658				17. INFORMANT Kansas City, Missouri Mrs. Eleanor Miller, 2305 Lawn Ave.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8169 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Multiple extreme intracranial (c) and intraabdominal injuries with secondary hemorrhage. INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Decapitated involved in head-on collision with another vehicle.							
20c. TIME OF INJURY Month, Day, Year 6/15 a.m. 4-30-66				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. DATE SIGNED May 2, 1966							
ACTUAL SIGNATURE Belden R. Heap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) BELDEN R. HEAP M.D. Colleator				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (street, city, town, or county) Booneville, Missouri							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-7-1966				23c. NAME OF CEMETERY OR CREMATORIUM Walnut Grove Cemetery			
24. FUNERAL DIRECTOR W.W. Chambers Co.				ADDRESS 1400 Chapin St., N. W. Washington, D. C.				25a. REC'D BY REGISTRAR DA			
								25b. REGISTRAR'S SIGNATURE Charles J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07203

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		b. COUNTY <i>Prince George's</i>	
c. LENGTH OF STAY IN 1B <i>7 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hosp. of Silver Spring</i>		d. STREET ADDRESS <i>4725 Naphs Ave</i>	
3. NAME OF DECEASED (Type or print)	First <i>Genevieve</i>	Middle <i>Ruth</i>	Last <i>Miller</i>
4. DATE OF DEATH Month <i>May</i>	Month <i>May</i>	Day <i>14</i>	Year <i>1966</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/26/08</i>
9. AGE (In years last birthday) <i>57</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS Days <i>7</i>	12. Hours <i>5</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Ohio</i>	
12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>	13. FATHER'S NAME <i>Ernest K. Hubbard</i>		
14. MOTHER'S MAIDEN NAME <i>Bessie Barton</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT Address <i>Robert H. Miller Same as #2 (Husband)</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis, primary site undetermined</i>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (This hospital) attended the deceased from <i>May</i> , 19 <i>66</i> , to <i>May 14, 1966</i> , that (I) (we) last saw the deceased alive on <i>5/14/1966</i> , and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>John Geiper</i>		22b. DATE SIGNED <i>5-14-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Jason Geiper, MD.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <i>800 PERSHING DRIVE Silver Spring, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/18/66</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Oak Spring</i>	23d. LOCATION (City, town or county) (State) <i>Canonsburg, Pa.</i>
24. FUNERAL DIRECTOR <i>Francis Gasch's Sons</i>	ADDRESS <i>Hyattsville, Maryland</i>	25a. REC'D BY REGISTRAR <i>MAY 17 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

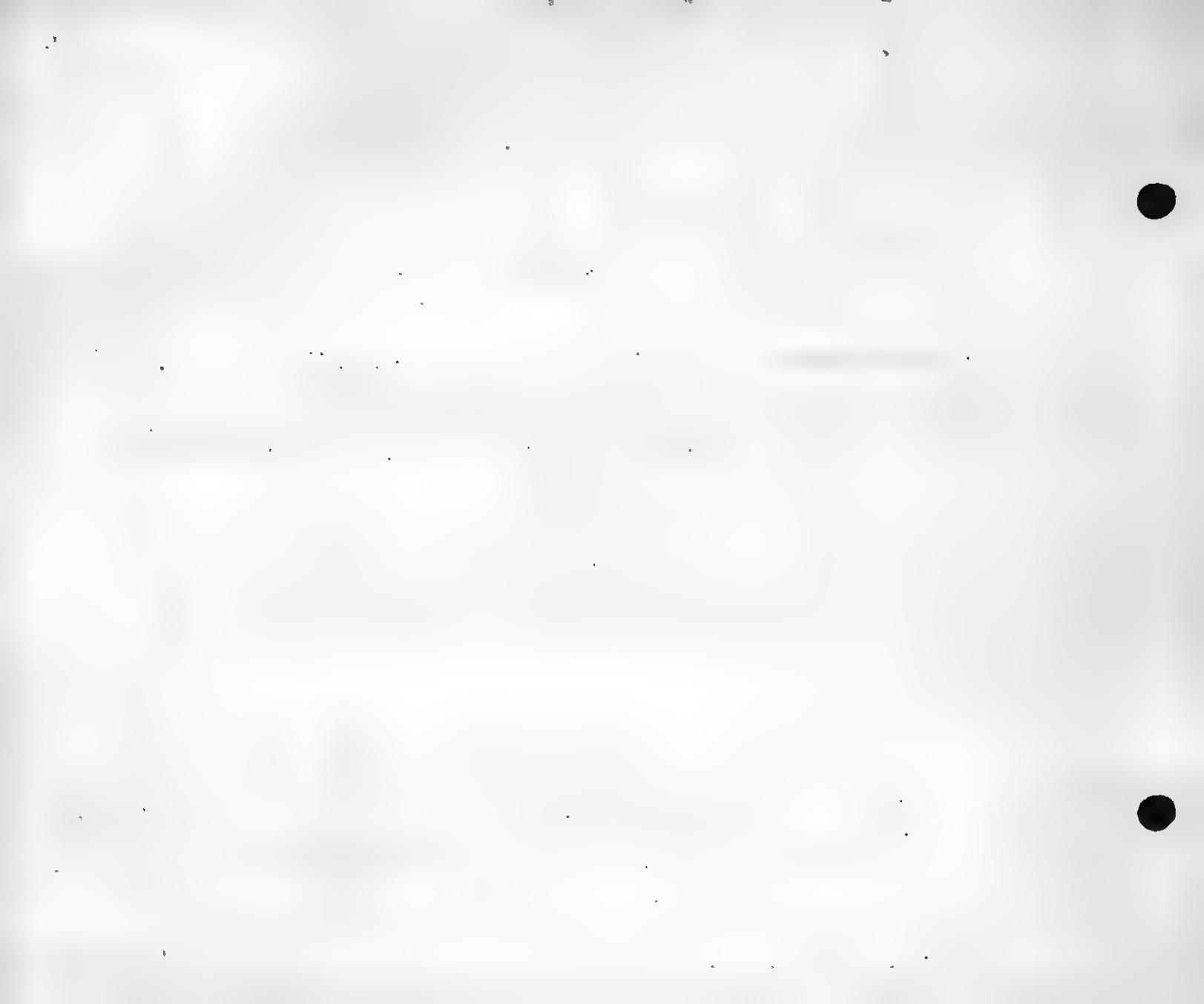


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and then event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE			b. COUNTY			07204		
Montgomery Maryland			Maryland			Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Silver Spring			24 days			Silver Spring					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Holy Cross Hospital			707 Downs Drive								
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
George			William		Miller	5	24	19	66		
5. SEX			6. COLOR DR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours	12. IF UNDER 24 HRS. Min.		
Male			White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/11/10	56 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS DR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Procurement manager			Navy Shore electronic center			Brooklyn, N.Y.			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME								
George W. Miller			Wilhelmina Pape								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY ND.			17. INFORMANT			Address		
yes			096-03-7464			Mrs. Edith S. Miller			707 Downs Drive Silver Spring, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cachexia			INTERVAL BETWEEN ONSET AND DEATH 3 wks.		
Ccnditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b)	DUE TO (c)	DUE TO (d)	Bronchogenic carcinoma with metastasis			6 mo		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
19											
21. I certify that (I) (this hospital) attended the deceased from April 30, 1966, to May 27, 1966, that (I) (we) last saw the deceased alive on May 27, 1966, and that death occurred at 11 AM, from the causes and on the date stated above.											
22a. SIGNATURE Raymond Bradshaw,			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 5/24/66					
22c. PHYSICIAN'S NAME (Type) Raymond Bradshaw			22d. ADDRESS 345 University Blvd., W., S. S., Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 27 May 1966			23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.			23d. LOCATION (City, town or county) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR John Thomas Warner E. Humphrey, Inc.			ADDRESS 8434 Georgia Avenue Silver Spring, Md.			25a. REC'D BY REGISTRAR MAY 27 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		



1
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										07205	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
<p>1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i></p>					c. LENGTH OF STAY IN 1B <i>1 hr 8 min</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban Hospital</i>						
e. MARYLAND					b. STATE <i>Virginia</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Norfolk</i> d. STREET ADDRESS <i>1233 Westover Ave</i>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <i>William Parker Moffett</i>					First <i>W</i> Middle <i>P</i> Last <i>Moffett</i>		4. DATE OF DEATH <i>May 8 1966</i>		Month <i>May</i> Day <i>8</i> Year <i>1966</i>		
5. SEX <i>Male</i> COLOR OR RACE <i>White</i>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-3-17</i>		9. AGE (in years last birthday) <i>48</i> yrs. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Floor Finisher</i>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>E. A. Moffett</i>					14. MOTHER'S MAIDEN NAME <i>Brady</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>					16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
							<i>Mrs. Wm. P. Moffett Same As #?</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Gunshot wound, cerebrum, self-inflicted</i> <i>976 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hour</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belton R. Keap</i> EXAMINER'S NAME (Type) <i>BELTON R. KEAP MD</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Address</i>						
					22. DATE SIGNED <i>May 8, 1966</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>5/11/66</i>					23c. NAME OF CEMETERY OR CREMATORIUM <i>Rosewood Cemetery</i> 23d. LOCATION (City, town or county) (State) <i>Virginia Beach Virginia</i>						
24. FUNERAL DIRECTOR <i>J. Wm. Lees Sons</i> ADDRESS <i>300 4th St., NE Washington, DC</i>					25a. REC'D BY REGISTRAR <i>MAY 12 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner - M.D.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
C7213		CERTIFICATE OF DEATH											
Item 3 File G-7206													
1. PLACE OF DEATH a. COUNTY		2. USUAL/RESIDENCE (Where deceased lived, If institution: Residence before admission)											
Montgomery		b. STATE D. C.											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY									
Silver Spring													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)											
Holy Cross Hospital		Washington											
e. IS RESIDENCE ON A FARM?													
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First THOMAS	Middle ROBERT	Last RAINES	4. DATE OF DEATH	Month May	Day 21	Year 1966					
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/24/1907	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours					
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			Yrs.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?						
Dentist		Oral Surgeon		New York			U.S. A.						
13. FATHER'S NAME Thomas Raines Monks		14. MOTHER'S MAIDEN NAME Nora Lynch											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Washington, D. C.		Address Mrs. Mary Monks 3715 48th St., N.W.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Ventricular Fibrillation													
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Chronic congestive failure & cardiomypathy													
DUE TO (c) Aortic regurgitation -2 Rheumatic heart disease													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
INTERVAL BETWEEN ONSET AND DEATH 1 day													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> p.m. Not White <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Washington, D.C.		(County) D.C.		(State) Maryland			
21. I certify that (I) (this hospital) attended the deceased from 1942, to May 21, 1966, that (I) (we) last saw the deceased alive on May 20, 1966, and that death occurred at 3:30 P.M. from the causes and on the date stated above.													
22a. SIGNATURE Thomas F. Keliher		22b. DATE SIGNED May 21, 1966											
22c. PHYSICIAN'S NAME (Type) Thomas F. Keliher, M.D.		22d. ADDRESS 3800 Reservoir Rd. N.W. Wash. D.C.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-24-1966		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery		23d. LOCATION (City, town or county) Silver Spring		(State) Md.					
24. FUNERAL DIRECTOR Joseph Lawler's Sons Inc.		ADDRESS 5130 Wisc. Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
DATE MAY 25 1966 Charles Judge													



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

67207

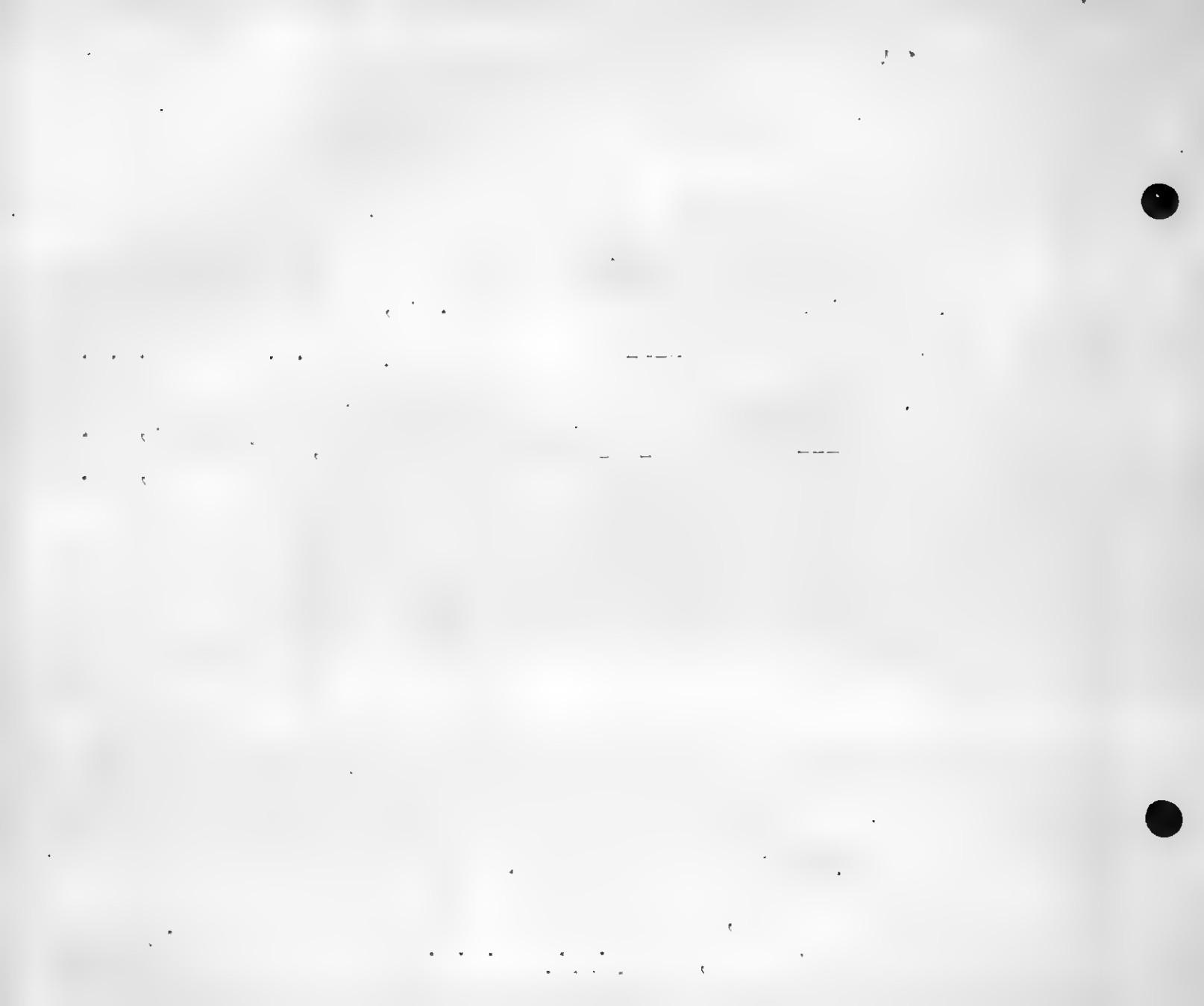
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M

C 4214

67207

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
Montgomery		b. STATE Maryland b. COUNTY Montgomery							
d. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wheaton Nursing Home		d. STREET ADDRESS 4504 Saul Road							
3. NAME OF DECEASED (Type or print) EDITH		First	Middle						
			Last						
4. SEX Female		5. COLOR OR RACE White	6. MARRIED WIDOWED	7. NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1879	9. AGE (in years last birthday) 86	10. MONTH 5	11. DAY 13	12. YEAR 1966
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Redfield Duryee		14. MOTHER'S MAIDEN NAME Mary Frances Foote							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-46-4688		17. INFIRMITY Edith Reynolds, 4504 Saul Road		Address Kensington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) OUE TO (c)		3. Bronchopneumonia Cerebrovascular Thrombosis Cerebral Atherosclerosis		Kensington, Md. 3 days		INTERVAL BETWEEN ONSET AND DEATH 6 yrs. 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pyelonephritis									
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
19									
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 19_____ and that death occurred at 1105 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Henry C. Scruggins Jr.						22b. DATE SIGNED 5/14/66.			
22c. PHYSICIAN'S NAME (Type) Henry C. Scruggins Jr.		22d. ADDRESS 5413 Cedar Lane Bethesda Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF May 16, 1966		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Suitland Md.		23d. LOCATION (City, town or county) Suitland, Md.		(State)	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Wash. D.C.		ADDRESS 5130 Wis Ave. N.W.		25a. REC'D BY REGISTRAR MAY 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
M 87215

CERTIFICATE OF DEATH

87208

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Wheaton

MARYLAND

c. LENGTH OF STAY IN 1b

(if not in hospital, give street address)

University Nursing Home

3. NAME OF
DECEASED
(Type or print)First
WilliamMiddle
Monroe

Mothershead

4. DATE
OF
DEATHMonth
MayDay
23Year
1966

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED
 NEVER MARRIED
 WIDOWED
 DIVORCED

8. DATE OF BIRTH

Feb. 2/1873

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Watchman

11. BIRTHPLACE (County & State, or foreign country)

Va

13. FATHER'S NAME

Robert Motherhead

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

577-09-2858

17. INFORMANT

Emma Miller

Address

Melvin Mothershead Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

 YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

Hour a.m.

19

p.m.

White Not White
at work at work

21. I certify that (I) (this hospital) attended the deceased from March 15, 1966 to May 23, 1966 that (I) (we) last saw the deceased alive on May 21, 1966, and that death occurred at 12 M, from the causes and on the date stated above.

22e. SIGNATURE

William Brainerd

22b. DATE SIGNED

5/26/66

22c. PHYSICIAN'S NAME (Type)

WM BRAINERD

M.D.

ATTENDING PHYS.

 MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

6124 Central Ave, Capitol Heights

(State)

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

5/26/66

23c. NAME OF CEMETERY OR CREMATORIUM

Congressional Cemetery

23d. LOCATION (City, town or county)

Washington

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Lee Funeral Home

ADDRESS

Washington, D. C.

25a. DATE

MAY 26 1966

25b. REGISTRATION DATE

MAY 20 1966

REGISTRAR'S SIGNATURE

Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE							
<i>Montgomery</i> <i>MARYLAND</i>				<i>Maryland</i> <i>b. COUNTY</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1B <i>24 hrs</i>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>				d. STREET ADDRESS <i>6 Nelson St</i>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
<i>F</i>	<i>W</i>	<input checked="" type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED	<i>By 3/9/28</i>	<i>38</i>	yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i>				10b. KIND OF BUSINESS OR INDUSTRY							
13. FATHER'S NAME <i>Daniel Kallenborg</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Milton R. Mullican same item # 2 (husband</i>							
218-20-0955				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARINA Promyia</i>											
754;				INTERVAL BETWEEN ONSET AND DEATH MINUTES,							
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.				<i>Subarachnoid Hemorrhage + (intraventricular)</i>							
(b) <i>Arterio Venous Malformation (Rt. Cerebral Peduncle)</i>				24 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19											
21. I certify that (I) (this hospital) attended the deceased from <i>5-29</i> , 19 <i>66</i> , to <i>5-30</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5/30</i> , 19 <i>66</i> , and that death occurred at <i>9th P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Francis C. Mayle</i>											
22c. PHYSICIAN'S NAME (Type) <i>Francis C. Mayle</i>				ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/31/66</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>6/2/66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Cemetery</i>		23d. LOCATION (City, town or county) <i>Rockville Montg. Md.</i>		(State)	
24. FUNERAL DIRECTOR <i>LYSON WHALER & H</i>				ADDRESS <i>1381 ROCKVILLE MD.</i>		25a. REC'D BY REGISTRAR <i>JUN 3 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

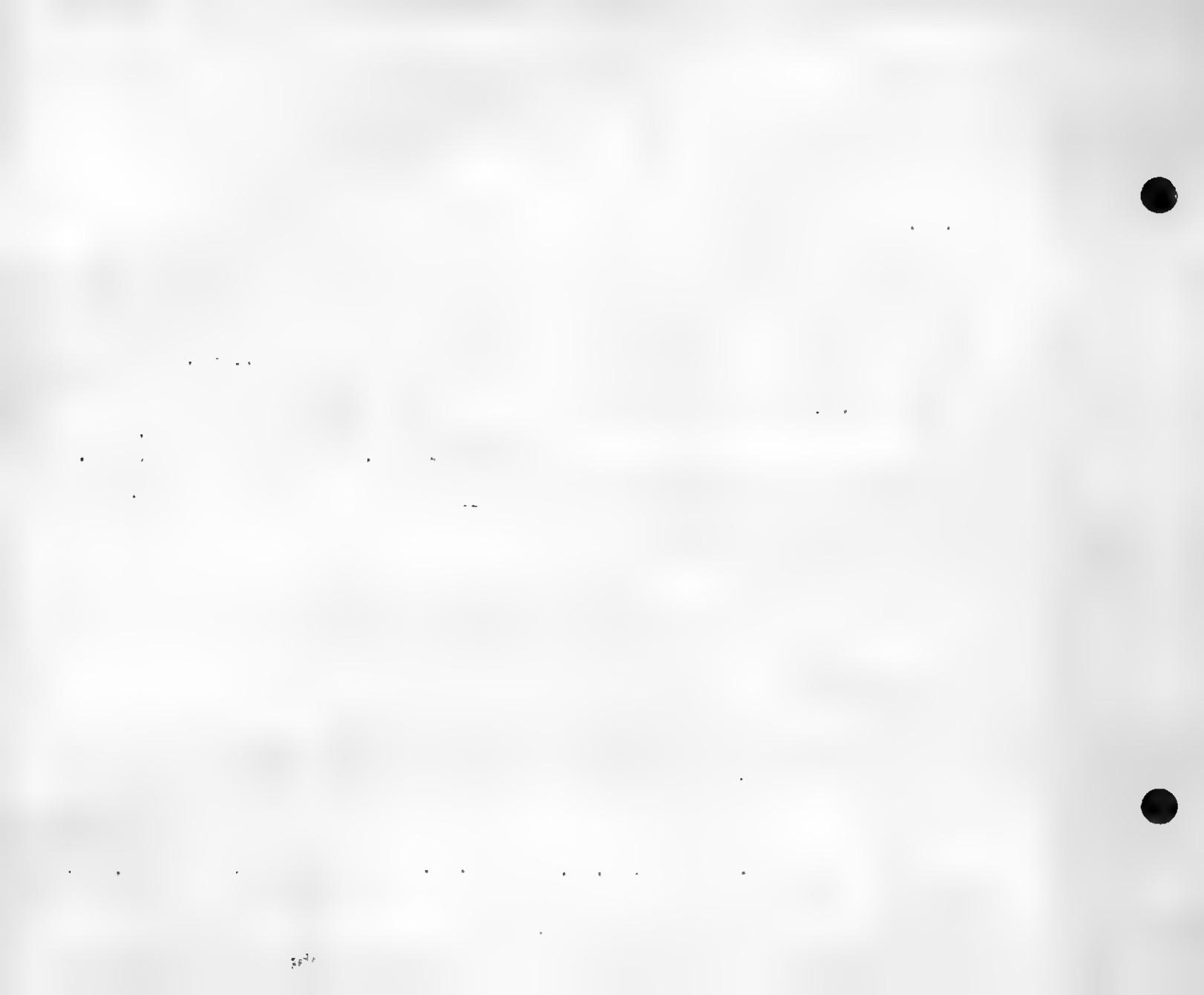
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send carbon papers pages and 2 and 3 to the State Dept. of Health prior to burial, cremation, or removal, and return event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN b 5 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. STREET ADDRESS 1017 South Quebec	
3. NAME OF DECEASED (Type or print) Baby		First Boy	Middle MURRAY
4. DATE OF DEATH May 17, 1966	Month May	Day 17	Year 1966
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH May 17, 1966	9. AGE (In years last birthday) yrs 5	10. IF UNDER 1 YEAR Months 5	11. IF UNDER 24 HRS Days 5
10a. US OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) Bethesda, Montgomery, Md.	
13. FATHER'S NAME Johnie R. Murray		14. MOTHER'S MAIDEN NAME Hiroko Matsuura	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Arlington Address Johnie Murray, 1017 South Quebec, Apt. 7/	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Prematurity and immaturity, Bilateral pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (<input checked="" type="checkbox"/>) (this hospital) attended the deceased from May 17, 1966 , to May 17, 1966 that (<input checked="" type="checkbox"/>) (we) last saw the deceased alive on May 17, 1966 , and that death occurred at 9:44 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Ronald F. Swanger</i>		22b. DATE SIGNED 18 May 1966	
22c. PHYSICIAN'S NAME (Type) Ronald F. Swanger, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 23, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National
24. FUNERAL DIRECTOR Charles Murphy		ADDRESS 3524 Columbia Pike, Arlington, Virginia	25a. REC'D BY REGISTRAR MAY 20 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

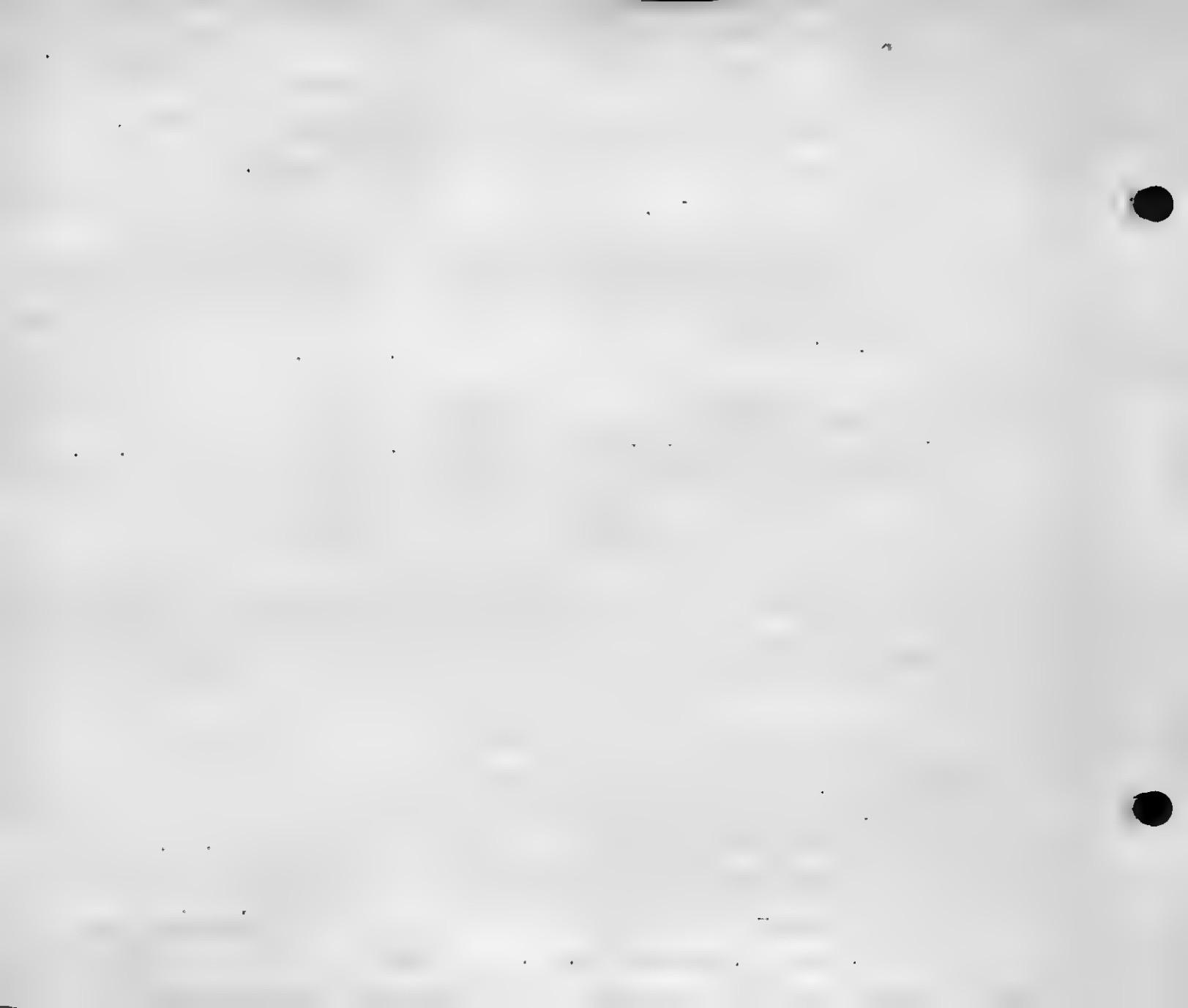
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07218 07211

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN lb 16Hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Roger	Middle Darby	Last Nicholls
4. DATE OF DEATH	Month May	Day 8th	Year 1966
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb 24th 1885
9. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10. INDUSTRY III	11. BIRTHPLACE (County & State, or foreign country) Montg. Co. Md.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME George Thomas Nicholls	
14. MOTHER'S MAIDEN NAME Courtney Burdette		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) If yes give war or date of service No	
16. SOCIAL SECURITY NO. 218-24-3140		17. INFORMANT Address Madeline T. Nicholls, Germantown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Adeno carcinoma - } DUE TO (c) upper left stem bronchus		INTERVAL BETWEEN ONSET AND DEATH 24 hours 6 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) A-H-D. & C-H-F.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 18, 1965 to May 8, 1966 , that (I) (we) last saw the deceased alive on May 7, 1966 , and that death occurred at 8 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher M.D.		22b. DATE SIGNED 5-9-66	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-11-66	
23c. NAME OF CEMETERY OR CREMATORIAL ParkLawn		23d. LOCATION (City, town or county) Rockville, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		25a. REC'D BY REGISTRAR MAY 11 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles J. Gartner	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										07212	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Boyle		C. LENGTH OF STAY IN 1b		a. STATE		Maryland		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Home		d. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Boyle		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	Months	Days	Hours	Min.
male		white			5/20/1907	58 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Residenceur		Business		Montgomery		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
John Thomas Nicholson		Selina Ann Mayhew									
16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
212-12-5959		Elma May Nicholson, Boyle, Md									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary											
141X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) following pneumonia											
DUE TO (c) Chronic asthma											
INTERVAL BETWEEN ONSET AND DEATH few hours 8 days years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19						May					
21. I certify that (I) (this hospital) attended the deceased from April - 2 - 1966, to May 7, 1966, that (I) (we) last saw the deceased alive on May 7, 1966, and that death occurred at 11 A.M. from the causes and on the date stated above.											
22a. SIGNATURE William C. Miller, M.D.											
22b. DATE SIGNED May 11, 1966											
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 73 Brooke Avenue, Ginterburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/11/66		23c. NAME OF CEMETERY OR CREMATORIUM Presbyterian		23d. LOCATION (City, town or county) Boyle		(State) Md.			
24. FUNERAL DIRECTOR		ADDRESS Constance C. Hilton Barnesville, Md.		25a. REC'D BY REGISTRAR DAT MAY 11 1966		25b. REGISTRAR'S SIGNATURE Charles J. George					

27 Oct

frontal lobe

posterior

posterior

posterior lateral

anterior

Posterior frontal lobe, anterior to anterior

anterior frontal lobe, anterior to anterior

7.

Posterior frontal lobe, anterior to anterior

Posterior frontal lobe, anterior to anterior

*Released from Dr. Reap for signature
by Dr. Coreau*

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07220

CERTIFICATE OF DEATH

07213

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <i>No town</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>DOA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>Henderson</i>	Last <i>Noble</i>
4. DATE OF DEATH <i>May 22 1966</i>	Month <i>May</i>	Day <i>22</i>	Year <i>1966</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 15, 1898</i>
9. AGE (In years last birthday) <i>57 yrs. 3 mos.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Laundry - Auto</i>	11. BIRTHPLACE (County & State, or foreign country) <i>PENNA.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Clarice Noble</i>		14. MOTHER'S MAIDEN NAME <i>CAROLINE Dinnit</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>578-07-0999</i>	17. INFORMANT <i>S. e C. Noble</i>	Address <i>2500 Franklin Road Mt. Ranier, Maryland</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>			
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerotic Heart Disease</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19	19		
21. I certify that (I) (this hospital) attended the deceased from <i>6/29, 1966</i> to <i>5/22, 1966</i> , that (I) (we) last saw the deceased alive on <i>5/13, 1966</i> , and that death occurred at <i>home</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Norman D. Coreau</i>		22b. DATE SIGNED <i>5/23/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Norman D. Coreau</i>	M.D. <input type="checkbox"/> ATTENDING PHYS. <i>Norman D. Coreau</i>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <i>3503 Perry St., Mt. Ranier, Maryland</i>			
23a. BUR. AL. CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>24 May 1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Prince George Co., Md.</i>
24. FUNERAL DIRECTOR <i>Frank Thomas Warren E. Piphrey, Inc.</i>		ADDRESS <i>8430 Georgia Avenue Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR <i>MAY 26 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1 M

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07221

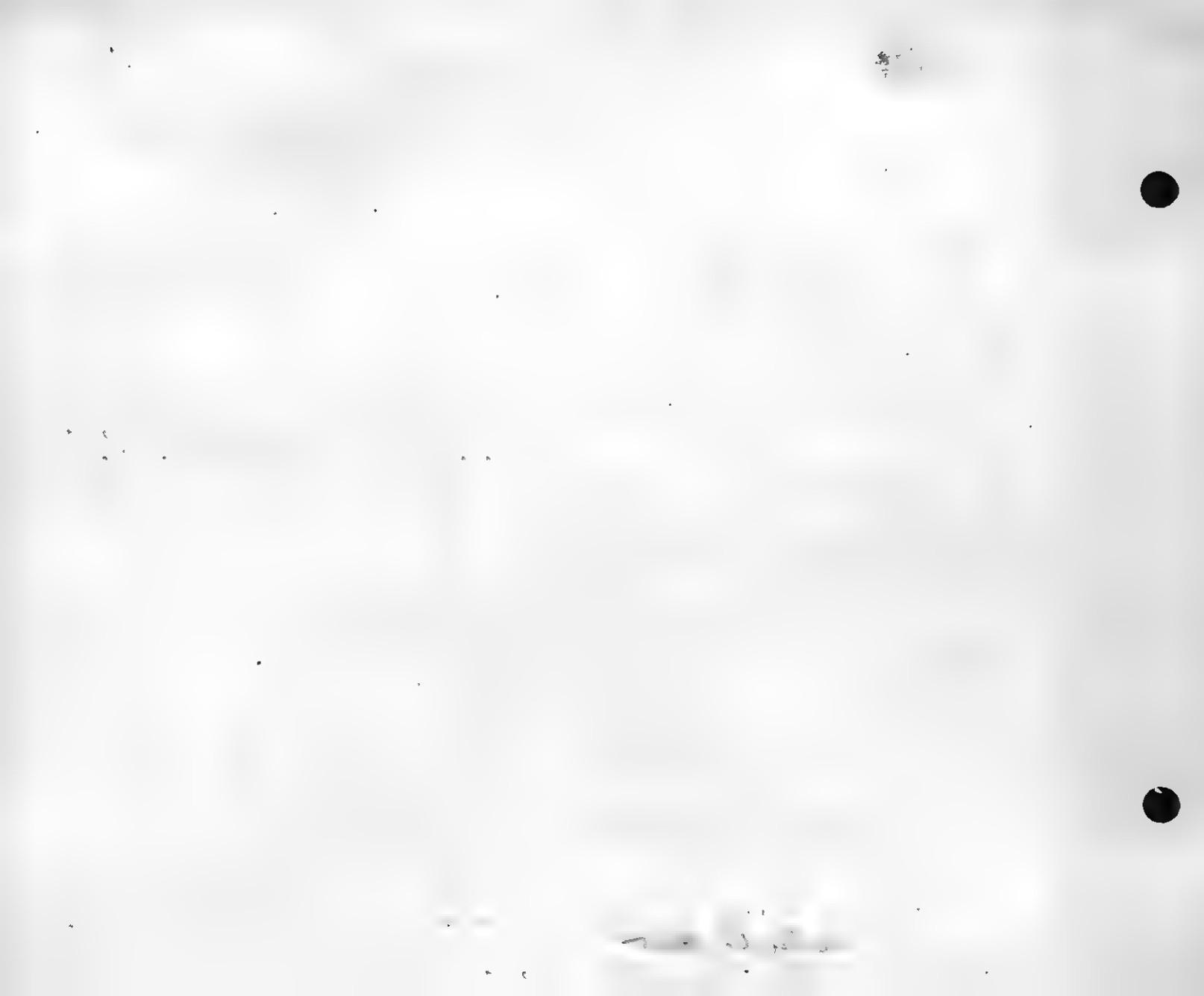
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07214

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE	
<i>Montgomery</i> MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Maryland</i> <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Outdoors</i>		c. LENGTH OF STAY IN 1b <i>DoA</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>Rockville</i> <i>10401 Grosvenor Pl</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Mayme Carolyn Noel</i>			
4. DATE DEATH		Month	Day Year
		<i>May</i>	<i>14 1966</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
<i>F</i>		<i>W</i>	<i>11-11-1916 49 yrs.</i>
8. DATE OF BIRTH		9. AGE (in years at last birthday)	10. IF UNDER 1 YEAR 11. BIRTHPLACE (State or foreign country)
		<i>11-11-1916</i>	<i>IF UNDER 24 HRS.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
<i>Housewife</i>		<i>Own Home</i>	<i>U.S.A.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>George F. Pushow</i>		<i>Matilda George</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
<i>No</i>		<i>Geo. R. Noel 5400 Pooks Hill Rd. Apt. 917 Bethesda, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Barbiturate - Poisoning</i>	
DUE TO (b)		<i>Overdose - Toxical.</i>	
DUE TO (c)		<i>1/2 h.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Took over 80 capsules of Johns.</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>10:50 5/11 1966</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home - Bethesda Mont. Md.</i>
20f. (City or town) <i>Bethesda</i>		(County) <i>Montgomery</i>	
		(State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>5/11/66</i>	
ACTUAL SIGNATURE <i>John S. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John S. Ball</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <i>Hagerstown, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/14/66</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Rest Haven Cemetery</i>
23d. LOCATION (City, town or county) <i>Hagerstown</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Wm. C. Host</i>		25a. REC'D BY REGISTRAR <i>MAY 17 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
Rest Haven Funeral Chapel			



Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

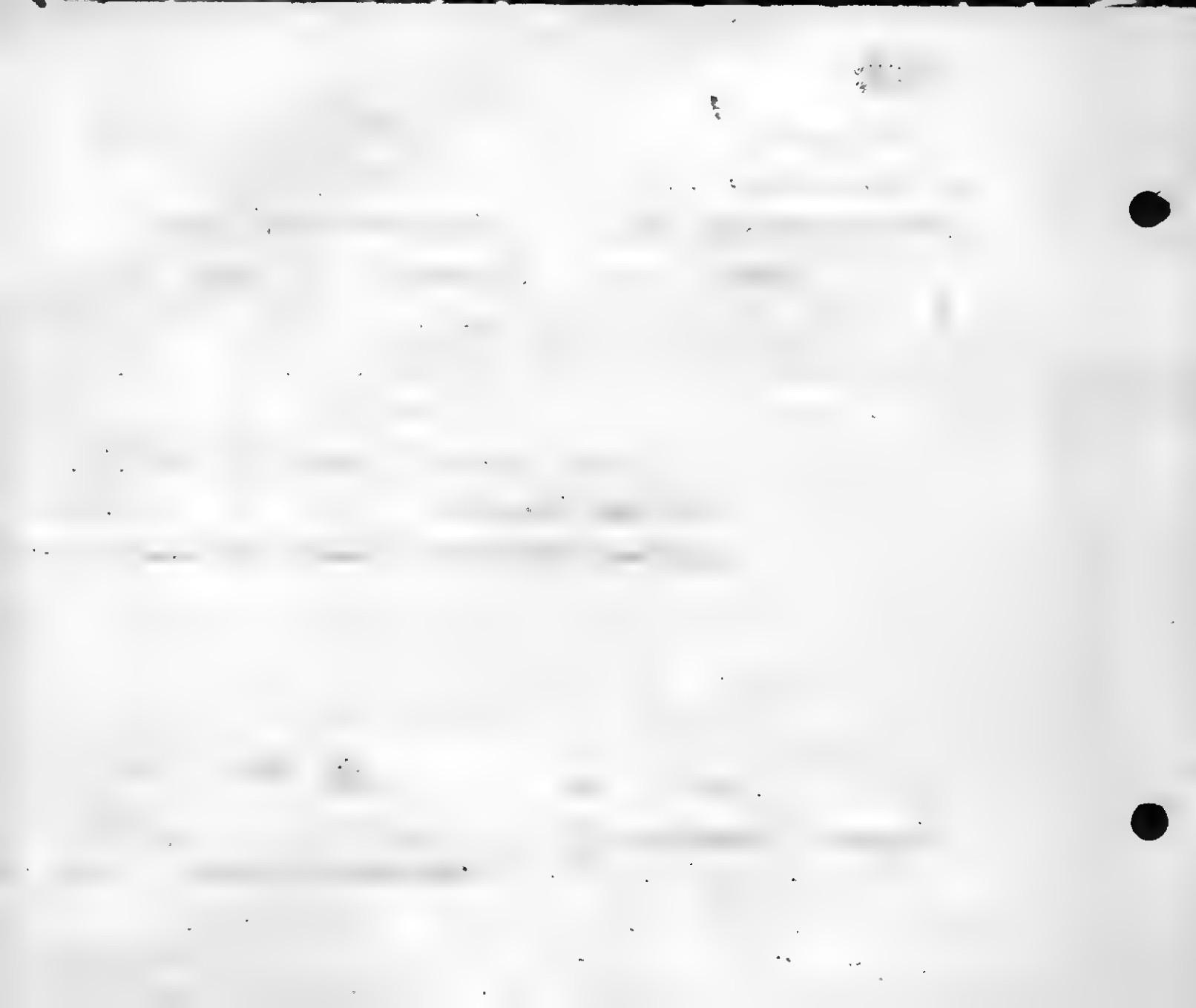
To Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07222

07215

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i>	b. COUNTY <i>Montgomery</i>					
D. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	C. LENGTH OF STAY IN 1B <i>5.5 Months 5 Days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	d. STREET ADDRESS <i>606 University Blvd, West</i>					
D. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Fairland Nursing Home</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Katie May O'Connor</i>	First <i>Katie</i>	Middle <i>May</i>	Last <i>O'Connor</i>	4. DATE OF DEATH Month <i>May</i>	Day <i>5</i>	Year <i>1966</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sep. 24, 1875</i>	9. AGE (In years last birthday) <i>90 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Owner and operator</i>	10b. KIND OF BUSINESS, OR INDUSTRY <i>Gasoline & Center</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D. C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>					
13. FATHER'S NAME <i>William G. Wheatley</i>	14. MOTHER'S MAIDEN NAME <i>Theresa Nelson</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>	16. SOCIAL SECURITY NO. <i>218-38-5676</i>	17. INFORMANT <i>Maurice W. O'Connor</i>	Address <i>2305 E Highway Silver Spring, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral thrombosis			INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b)	Hypertensive arteriosclerotic cardiovascular disease 10 years						
	DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to May 5, 1966, that (I) (we) last saw the deceased alive on May 5 1966, and that death occurred at 5:30 PM, from the causes and on the date stated above.		22a. SIGNATURE <i>Raymond Bradshaw, Jr.</i>	22b. DATE SIGNED <i>5/5/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>RAYMOND BRADSHAW, JR MD</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMAT. ON REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9 May 1966</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Washington, D. C.</i>				
24. FUNERAL DIRECTOR <i>Warren E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>	25a. REC'D BY REGISTRAR <i>MAY 9 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

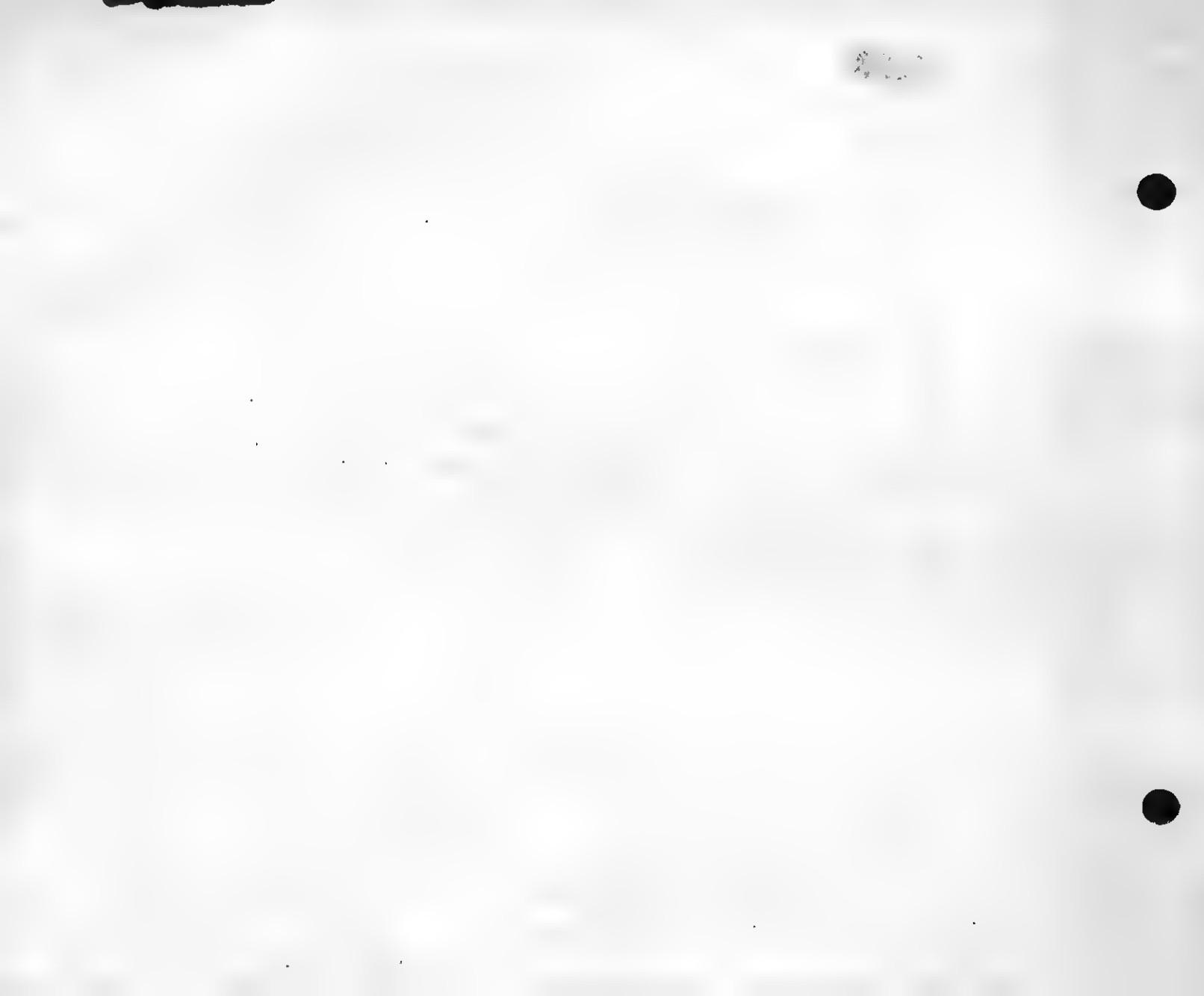
07228

CERTIFICATE OF DEATH

07216

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
c. LENGTH OF STAY IN lb <u>13 days</u>		e. STREET ADDRESS <u>3812 Tolerances DR.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nelson B. O'Neal</u>		4 DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1966</u>	
S SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-20-58</u> 9. AGE (In years lost birthday) <u>11</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banking</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Martinsburg, West Va</u>	
13. FATHER'S NAME <u>Robert O'Neal</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes give war or dates of service <u>Armeny</u>		16. SOCIAL SECURITY NO <u>599-22-1886</u> 17. INFORMANT <u>Evelyn P. O'Neal</u> 18. Address <u>3812 Inverness Dr. P.O. Box 121, Ch. Ch., Md.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1621</u> DUE TO <u>Bronchogenic carcinoma i metastasis</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema + Chronic L. bronis</u> ONSET AND DEATH (c) <u>of lungs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Maryland</u> (County) <u>Maryland</u> (State) <u>Maryland</u>
21. I certify that (I) (this hospital) attended the deceased from <u>March 23, 1966</u> , to <u>May 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 15, 1966</u> , and that death occurred at <u>6:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>William F. Luckett</u>		22b. DATE SIGNED <u>5-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM F. LUCKETT</u>		22d. ADDRESS <u>5000 PENO Road, N.W. - WASH. DC.</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-19-66</u>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Rosedale</u>
24. FUNERAL DIRECTOR <u>Joseph Gantner's Sons</u>		25a. ADDRESS <u>5130 Wisconsin Ave., N.W., D.C.</u>	25b. RECD BY REGISTRAR <u>Charles Judge</u> DA <u>MAY 23 1966</u>



FOR STATE
HEALTH DEPT.

3224

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

37217

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 1½ hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring	
3. NAME OF DECEASED (Type or print) Snerry Lynn Crndorff		First Middle Last	4. DATE OF DEATH Month May Day 1 Year 1966
S SEX Female	6 COLOR OR RACE White	7 MARRIED WIDOWED	8 NEVER MARRIED DIVORCED
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX Student		10b KIND OF BUSINESS OR INDUSTRY Public school	
11b BIRTHPLACE (State or foreign country) Washington, D.C.		9 AGE (in years last birthday) yrs 10 yrs	
13. FATHER'S NAME Loring Crndorff, Jr.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Father, Loring Crndorff, Jr.		Address 304 Colesville Manor Drive Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 124 DUE TO (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.) (b) DUE TO (c)		Multiple trauma including basilar skull fracture sustained when struck by auto.	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a EXTERNAL CAUSE WAS PRIMAR X OR CONTRIBUTING CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18) Deceased, a pedestrian, was struck by auto while walking along highway.	
20c TIME OF INJURY Month, Day, Year 2:15 pm 5/1 1966		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Name farm factory, street, office bldg., etc.) Street Silver Spring Montg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED May 2, 1966	
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or county)	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		23a BURIAL OR CREMATION REMOVAL (Specify) Burial	
23b DATE THEREOF May 4, 1966		23c NAME OF CEMETERY OR CREMATORIAL ADDRESS Asbury Methodist Church	
24. FUNERAL DIRECTOR John Thomas Warner E. Pumphrey, Inc. 8434 Ga., Ave., S.S., Md.		23d LOCATION (City or Town) Mooretfield, West Virginia County (State)	
		25a. REG'D BY REG. STRR MAY 9 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07225

CERTIFICATE OF DEATH

C7218

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the deceased.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN b. <u>11 days.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		d. STREET ADDRESS <u>620 Anderson Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First <u>Millard</u> Middle <u>E</u> Last <u>Peake</u>		4. DATE OF DEATH Month <u>5</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAXI DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BEETHESDA Cab Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Millard Peake Jr</u>		14. MOTHER'S MAIDEN NAME <u>Margaret A. Tucker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Navy</u>		16. SOCIAL SECURITY NO. <u>578-18-4757</u>	
17. INFORMANT <u>daughter Joan De Vries</u>		Address <u>Gardening</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fulminating Septicemic</u> DUE TO <u>2/1/66</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Probable gm - Organism</u> DUE TO (c) <u>Delirium Tremens</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Convalescent - Hemorrhagic Gastritis & Hemorrhage</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u>809 Veirs Mill Road, Rockville, Md.</u>
20f. (City or town) <u>Rockville</u> (County) <u>Montgomery</u> (State) <u>Md.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/19/66</u> to <u>5/19/66</u> that (I) (we) last saw the deceased alive on <u>5/19/66</u> , and that death occurred at <u>first</u> from causes and on the date stated above.		22b. DATE SIGNED <u>5/19/66</u>	
22a. SIGNATURE <u>Stephen Jones</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22d. ADDRESS <u>809 Veirs Mill Road, Rockville, Md.</u>
22c. PHYSICIAN'S NAME (Type) <u>Stephen Jones</u>		23a. BURIAL CREMATION, BURIAL (Specify) <u>CREMATION</u>	
23b. DATE THEREOF <u>5/21/66</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Rockville</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. ADDRESS <u>1331 Rockville Pike</u>	
25b. REC'D BY REGISTRAR <u>MAY 23 1966</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

07226

CERTIFICATE OF DEATH

07220

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and retain, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>1 1/2 hr.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>	
f. STREET ADDRESS <i>1003 Thimblewood Lane</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <i>A. Williams</i>		First <i>Albert</i>	Middle <i>Postel</i>
4 DATE OF DEATH Month <i>May</i> Day <i>8</i> Year <i>1966</i>			
5 SEX <i>m</i>	6 COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <i>Jan. 5 1908.</i>	8. DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <i>38 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Holyst</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Albert Postel</i>		14. MOTHER'S MAIDEN NAME <i>Dorothy Williams</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-44-0277</i>	
17. INFORMANT <i>Mrs. Dorothy Postel aborn</i>		Address <i>Same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis, myocardial, recent</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</i>		 <i>Arteriosclerosis, coronary disease</i>	
(b) <i>Arteriosclerosis, coronary disease</i>		DUE TO <i>Arteriosclerosis, coronary disease</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>333 M</i>
20f. (City or town) <i>Prince Georges Co.</i> (County) <i>Md.</i> (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May 8</i> , 1966, to <i>May 8</i> , 1966, that (I) (we) last saw the deceased alive on <i>May 8</i> , 1966, and that death occurred at <i>333 M</i> , from causes and on the date stated above			
22a. SIGNATURE <i>George Sharpe</i>		22b. DATE SIGNED <i>10-May-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>George Sharpe</i>		22d. ADDRESS <i>10511 Summit Ave. Kensington, Md.</i>	
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>5/11/1966</i>	23c. NAME OF CEMETERY OR CREMATORIALY <i>Cedar Hill Crematory</i>
23d. LOCATION (City or Town) <i>Prince Georges Co.</i> (County) <i>Md.</i> (State)			
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	25a. REC'D BY REGISTRAR <i>MAY 17 1966</i>
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c&d F97m #G377 6/15/66 pc

07227

CERTIFICATE OF DEATH

07221

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN lb 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY// Gaithersburg, Maryland		b. COUNTY MONTGOMERY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS R.R. #2 BROOKE/GROVE/FOUNDATION/				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) CAROLINE		First	Middle	Last	4. DATE OF DEATH MAY 19 1966	Month	Day	Year
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-70	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY --			11. BIRTHPLACE (County & State, or foreign country) MARYLAND		
13. FATHER'S NAME F. PRICE				14. MOTHER'S MAIDEN NAME LAURA BRADY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT MEDICAL RECORDS,			Address OLNEY, MARYLAND
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis - Genit. Vess.								
4500 DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1947 May 19, 1966		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 18 1966 , and that death occurred at 9:25 A.M. from causes and on the date stated above.								
22a. SIGNATURE Jack Schumacher								
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M.D.		22b. DATE SIGNED MAY 23 1966						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 21 1966		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Taber		23d. LOCATION (City or Town) (County) (State) Eatonson Montgomery Md.		
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville Md.		25a. REC'D BY REGISTRAR MAY 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

1970-1971
1971-1972

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07223

CERTIFICATE OF DEATH

07222

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN 1B

3 mos. 26 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Holy Cross Hospital

3. NAME OF
DECEASED
(Type or print)

First
Edna

Middle
Chiawell

Last
Pumphrey

4. SEX

Female

5. COLOR OR RACE

White

6. MARRIED
WIDOWED DIVORCED

7. NEVER MARRIED

8. DATE OF BIRTH

April 17, 1907

9. AGE (In years last birthday)

59 yrs.

10. FUNDER 1 YEAR FUNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Funeral Director Own Funeral Home Dickerson, Maryland U. S. A.

13. FATHER'S NAME

Edward Lee Chiawell

14. MOTHER'S MAIDEN NAME

Naomi North

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give war or dates of service)

No 216-16-0449 Mrs. James R. Miller Galesville, Maryland

Address Church Lane

INTERVAL BETWEEN ONSET AND DEATH

3-4 weeks

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

237X

Brain Aneurysm

DUE TO

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 20d. INJURY OCCURRED

p.m. While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (the hospital) attended the deceased from February 9, 1942, to May 10, 1966, that (I) (we) last saw the deceased alive on May 10, 1966, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

W. B. Wardrop, M.D.

22b. DATE SIGNED

May 11, 1966

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

808 Pershing Drive, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 23b. DATE THEREOF

13 May 1966 23c. NAME OF CEMETERY OR CREMATORIUM

Arlington National Cemetery 23d. LOCATION (City, town or county) (State)

Arlington, Virginia

24. FUNERAL DIRECTOR

John Joseph J. Steka 24b. ADDRESS

8434 Georgia Avenue

Silver Spring, Md.

25a. REC'D BY REGISTRAR

Charles Judge

25b. REGISTRAR'S SIGNATURE

